Senior Health Products

This chapter will discuss senior health products, including government-sponsored programs of Medicare and Medi-Cal. You will also learn about the Health Insurance Counseling and Advocacy Program (HICAP), how it functions, and who it serves. By the end of this chapter, you should be able to explain the differences between senior health products, including eligibility requirements, basic benefits, and services provided. This chapter is full of detail. To remember all the information in this chapter, it may help you to imagine different scenarios and quiz yourself about how much coverage would be provided under each type of policy.

TERMS TO KNOW

Benefit period — a period of time during which benefits are paid under the policy
Cost-sharing — sharing of expenses between the insured and the insurance company through deductibles, copays and coinsurance
Enrollee — a person enrolled in a health insurance plan, an insured (doesn't include dependents of the insured)
HMO — Health Maintenance Organization: a prepaid medical service plan in which specified medical service providers contract with the HMO and which focus on preventive care
Network provider — a provider who enters into a contractual arrangement with other providers to provide medical services to the network subscribers
Outline of coverage — a document required in all health insurance policies that provides a full coverage disclosure to the applicant

A. Medicare

Educational Objective:

III.D.1. Regarding Medicare, be able to:

a. Describe Original Medicare and Medicare Advantage
b. Identify who is eligible for coverage

1. Nature, Financing, and Administration

Medicare is administered by The Center for Medicare and Medicaid Services (CMS), which is a division of the United States Department of Health and Human Services. Medicare is divided into 4 parts:

1. **Part A (Hospital Insurance)** is financed through a portion of the payroll tax (FICA);
2. **Part B (Medical Insurance)** is financed from monthly premiums paid by insureds and from the general revenues of the federal government;

3. **Part C (Medicare Advantage)** allows people to receive all of their health care services through available provider organizations; and
4. **Part D (Prescription Drugs)** is for prescription drug coverage.

Note, however, that the term **Original Medicare** refers to Part A - Hospital Insurance, and Part B - Medical Insurance only. It covers health care from any doctor, health care provider, hospital or facility that accepts Medicare patients. It usually does not cover prescription drugs. Original Medicare does not require the patient to choose a primary care doctor, nor does it require a referral to see a specialist, as long as the specialist is enrolled in Medicare.

Know This! Part A is hospital insurance; Part B is medical insurance.

2. Eligibility

Medicare is a federal medical expense insurance program for people **age 65** and older even if the individual continues to work. Medicare benefits are also available to anyone, **regardless of age,** who has been entitled to Social Security disability income benefits for 2 years or has permanent kidney failure (End Stage Renal Disease — ESRD).

Persons age 65 years or older who are recent green card holders (permanent residents) or new immigrants to the U.S. and never worked in the U.S. may not immediately qualify for Medicare. If they don't qualify for free Medicare, they can still purchase it, if the following eligibility requirements are met:

- Are 65 years of age or older;
- Have recently become a U.S. citizen by naturalization and haven't worked enough quarters to have social security coverage; and
- Are lawfully admitted aliens (green card holders) who have constantly lived in the United States **for 5 years** or longer and don't qualify for the Social Security benefits.

While an individual becomes eligible for Medicare upon turning age 65, federal laws extend primary coverage benefits under the employer's plan to active older employees regardless of age. In other words, employer plans usually continue to be **primary** coverage, and Medicare is **secondary** coverage.

Medicare is not part of the Health Insurance Marketplace, which is a key component of the Affordable Care Act that allows qualified individuals, families, and employees of small businesses to obtain health insurance. When considered eligible for Medicare Part A, a person will not qualify for Marketplace tax credits to help pay for premiums or reductions in cost-sharing. An insured can keep a Marketplace plan after Medicare coverage starts; however, any premium tax credits and reduced cost-sharing through the Marketplace will stop.

3. Enrollment Periods

Initial enrollment period (IEP) is a 7-month period during which an individual may enroll into Medicare Part B program that usually begins 3 months before the month in which the individual turns age 65, and ends 3 months after that after the birthday month.

If a person enrolls in Medicare after the Initial Enrollment Period ends, the person may have to pay a late enrollment penalty.

General Enrollment period runs from January 1 through March 31 of each year. The individuals who did not sign up for Medicare Part B when they were first eligible, may sign up during this enrollment period. However, the cost of Medicare Part B goes up 10% for each full 12-month period that the individual could have had Medicare Part B but didn't. The enrollee will have to pay this penalty each time they pay premiums, for as long as they have Part B (lifetime penalty). In addition, the penalty increases the longer an individual goes without Part B coverage.

Anyone who qualifies for Medicare may also purchase a Medicare Supplement and pay the necessary premium for those additional benefits. Under OBRA, Medicare supplement insurance may not discriminate in pricing or be denied on the basis of an applicant's health status, claims experience, receipt of health care or medical condition. An open enrollment period is a 6-month period that guarantees the applicants the right to buy Medigap once they first sign up for Medicare Part B. In essence, to buy a Medigap policy, the applicant must generally have both Medicare Part A and Part B.

Medicare Supplement policies cannot be used to pay for Medicare Advantage (Part C) copayments, deductibles, or premiums. Additionally, insurers are prohibited from selling Medicare Supplement policies to anyone already enrolled in Medicaid.

Special enrollment period (SEP) is available to individuals who are eligible for Medicare Part B based on their age, but who waited to enroll because they had a group health plan through their own or their spouse's employer. These individuals may sign up for Part B anytime while they are still covered by the group health plan, or they may sign up during the 8 months following either the termination of the group plan or employment (whichever is first).

4. Part A - Hospital Insurance

Educational Objective:

III.D.1.c. Regarding Medicare Part A, be able to identify:

i. Inpatient coverage (does not include physician or surgeon charges)
ii. Benefit period
iii. Hospital admission deductible
iv. Copayments for hospital days 61 to 90, and the 60 lifetime reserve days
v. Home care and hospice may be covered following a hospitalization
vi. Mental health inpatient hospitalization lifetime limitations

Medicare Part A helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

Individual Eligibility Requirements

An individual is eligible for Medicare Part A, Hospital Coverage, by qualifying for one of the following conditions:

- A citizen or a legal resident of the United States age 65 or over and qualified for Social Security or Railroad retirement benefits — *Aged*;
- Is 65 years old or over and entitled to monthly Social Security benefits based upon the spouse's work record, and the spouse is at least 62;
- Is younger than 65, but has been entitled to Social Security disability benefits for 24 months — *Disabled;*
- Has End Stage Renal Disease (ESRD) — permanent kidney failure that requires dialysis or a transplant; and/or
- Has ALS (Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease) — automatically qualifies for Part A the month disability benefits begin.

Individuals who are not receiving those types of benefits need to sign up for Part A, even if they are eligible for premium-free Part A.

In addition, monthly Part A premiums are required when a beneficiary is not "**fully insured**" under Social Security, meaning they have not earned **40 quarters** of coverage (the equivalent of 10 years of work), and therefore, are entitled to receive Social Security retirement, premium-free Medicare Part A, and survivor benefits. If the beneficiary has paid Medicare taxes for fewer than 30 quarters, the standard Part A premium is $506. If Medicare taxes have been paid for 30-39 quarters, the standard Part A premium is $278.

Enrollment

Those who want to sign up for Medicare Part A have the following three options:

- **Initial enrollment period:** when an individual first becomes eligible for Medicare (starting 3 months before turning age 65, ending 3 months after the 65th birthday);
- **General enrollment period:** between January 1 and March 31 each year;
- **Special enrollment period:** at any time during the year if the individual or his/her spouse is still employed and covered under a group health plan.

Those who are not eligible for premium-free Part A can purchase the coverage for a monthly premium. If individuals fail to sign up for Part A when they are first eligible, the monthly premium may go up 10% unless the person becomes eligible for a special enrollment period.

Coverages and Cost-sharing Amounts

Inpatient Hospital Care — Hospital insurance helps pay for up to 90 days in a participating hospital in any benefit period, subject to a deductible. The first 60 days are covered at 100% of approved charges after the deductible is met. The next 30 covered days are paid, but they are paid with a daily copayment. Every Part A insured has a lifetime reserve of 60 days of hospital care. The lifetime reserve days have a copayment that is twice that of days 61 through 90, and they are nonrenewable. Covered services include semi-private room, meals, regular nursing services, operating and recovery room costs, hospital costs for anesthesia, intensive care and coronary care, drugs, lab tests, X-rays, medical supplies, appliances, rehabilitation services, and preparatory services related to kidney transplant surgery. Blood is also covered, except for the first 3 pints.

Under the inpatient hospital stay, Part A does NOT include private duty nursing, a television or telephone in your room. It also does not include a private room unless medically necessary. In addition, inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

Sixty (60) days of non-use of the inpatient hospital benefit starts a new benefit period and a new deductible.

Skilled Nursing Facility Care — Part A helps pay for up to 100 days in a participating skilled nursing facility in each benefit period, following a 3-day inpatient hospital stay for a related illness. To get this type of care, the insured's doctor must certify that daily skilled care is necessary. Covered expenses include semi-private room, meals, regular nursing and rehabilitation services, and other supplies.

Home Health Care — For an individual confined to the home and meeting certain other conditions, hospital insurance can pay the full approved cost of home health visits from a participating home health agency. There is no limit to the number of covered visits. Covered services include part-time skilled nursing care, physical therapy, and speech therapy. Hospital insurance also covers part-time services of home health aides, occupational therapy, medical social services and medical supplies and equipment.

Hospice Care — Under certain conditions, hospital insurance can help pay for hospice care for terminally ill insureds, if the care is provided by a Medicare-certified hospice. Covered services include doctor services, nursing services, medical appliances, supplies including outpatient drugs for pain relief, home health aide, homemaker services, therapies, medical social services, short-term inpatient care including respite care, and counseling.

Know This! Medicare Part A does not cover outpatient hospital care. That's covered under Medicare Part B.

The **benefit period** begins when the insured is admitted as an inpatient in a hospital or a skilled nursing facility. It ends when the insured have not received any inpatient hospital care for consecutive 60 days. If the insured goes to a hospital or a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods; however, the inpatient hospital **deductible applies to each benefit period.**

Medicare Part A: Hospital Insurance Covered Service
Reference Chart

BENEFITS	MEDICARE PAYS	YOU PAY
HOSPITALIZATION:		
First 60 days	All but the deductible	Deductible
Days 61-90	All but daily deductible	Daily deductible

After day 90 (up to 60 days)*All but daily deductibleDaily deductible

After lifetime reserve daysNothingAll costs

SKILLED NURSING FACILITY CARE:

First 20 days100% of approved amountNothing

Days 21-100All but daily deductibleDaily deductible

Beyond 100 daysNothingAll cost

HOME HEALTH CARE:

For as long as you meet Medicare requirements for home health care benefits.	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment

HOSPICE CARE:

For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care

BLOOD:

Unlimited if medically necessary	All but first 3 pints per calendar year	For first 3 pints**

** 60 lifetime reserve days. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.*
***To the extent that three pints of blood are paid for or replaced under one part of Medicare during the calendar year. They do not have to be paid for or replaced under the other part.*

5. Part B - Medical Insurance

Educational Objective:

III.D.1.d. Regarding Medicare Part B, be able to identify:

i. Enrollment in Part B
ii. A monthly premium is paid by all beneficiaries
iii. Annual deductible
iv. Coinsurance (generally 80-20)
v. Benefits

Medicare Part B pays for doctor's services and a variety of other medical services and supplies that are not covered by hospital insurance. Most of the services needed by people with permanent kidney failure are covered only by medical insurance.

Individual Eligibility Requirements

Part B is optional and offered to everyone who enrolls in Part A. Part B is funded by monthly premiums and from the general revenues of the federal government. Most people enrolled in Medicare Part B pay the **standard monthly premium**. However, if an insured's modified adjusted gross income reported on IRS tax return is above a certain amount, the insured may be required to pay a higher premium.

Enrollment

When you become eligible for Part A, you are told that you will get and have to pay for Part B unless you decline it. If you later decide you want Part B after initially declining it, you must wait until the next general enrollment period (Jan. 1 through Mar. 31) to enroll.

Know that enrollment in Medicare Part B may be **rejected or delayed** when employer coverage is primary due to the active employment of the individual at age 65 (or younger if with ESRD), or their spouse, or a parent of a disabled dependent.

Coverages and Cost-sharing Amounts

After the annual medical insurance deductible is met, medical insurance will generally pay for 80% of the approved charges for covered expenses for the remainder of the year. There is no maximum out of pocket limit on the 20% coinsurance payable for Part B expenses.

Doctor Services — Part B covers doctor services no matter where received in the United States. Covered doctor services include surgical services, diagnostic tests and X-rays that are part of the treatment, medical supplies furnished in a doctor’s office, and services of the office nurse.

Outpatient Hospital Services — Part B covers outpatient hospital services received for diagnosis and treatment, such as care in an emergency room, outpatient clinic, or a hospital.

Home Health Visits — Medicare will pay for home health services as long as these services are recommended by the insured's doctor and the insured is eligible. However, these services are provided on a part-time basis with limits on the number of hours per day and days per week. The services that are not fully covered by Medicare will get coverage from Medicaid.

Other Medical and Health Services — Under certain conditions or limitations, medical insurance covers other medical services and supplies. Some examples are as follows: ambulance transportation; home dialysis equipment, supplies, periodic support services, independent laboratory tests, oral surgery, outpatient physical therapy, speech pathology services, and X-rays and radiation treatments.

Prescription Drugs (limited coverage) — Only medicines that are administered in a hospital outpatient department under certain circumstances, such as injected drugs at a doctor’s office, some oral cancer drugs, or drugs that require durable

medical equipment (like a nebulizer or infusion pump), are covered. Other than the examples above, insured under Part B will have to pay 100% for most prescription drugs, unless covered by Part D.

Outpatient Treatment of Mental Illness — Medicare covers outpatient treatment of an approved condition (such as depression or anxiety) in a doctor's office or other health care provider's office or hospital outpatient department. Generally, the enrollee pays 20% of the Medicare-approved amount (coinsurance); Part B deductible also applies. Note that inpatient mental health care is covered under Part A.

Yearly "wellness" visit — In addition to a "Welcome to Medicare" preventive visit available during the first 12 months, Medicare Part B covers annual "wellness" visit during which the insured and the provider can develop or update a personalized plan for disease prevention. There is no out-of-pocket cost for the insured for these visits if the doctor or other qualified health care provider accepts assignments. If the doctor or the health care provider performs additional tests or services during the same visit that are not covered under this preventive benefit, the insured may have to pay coinsurance, and Part B deductible may also apply.

Exclusions

Medical insurance under Part B of Medicare **does not cover** the following:

- Private duty nursing;
- Skilled nursing home care costs over 100 days per benefit period;
- Intermediate nursing home care;
- Physician charges above Medicare's approved amount;
- Most outpatient prescription drugs;
- Care received outside the United States;
- Custodial care received in the home;
- Dental care (except dental expenses resulting from an accident only), cosmetic surgery, eyeglasses, hearing aids, orthopedic shoes, acupuncture expenses; or
- Expenses incurred due to a war or act of war.

Claims Terminology and Other Key Terms

The following are claims terminology and other key terms applicable to Medicare:

- **Actual Charge** — The amount a physician or supplier actually bills for a particular service or supply.
- **Ambulatory Surgical Services** — Care that is provided at an ambulatory center. These are surgical services performed at a center that do not require a hospital stay unlike inpatient hospital surgery.
- **Approved Amount** — The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare.
- **Assignment** — The physician or a medical supplier agrees to accept the Medicare-approved amount as full payment for the covered services.
- **Carriers** — Organizations that process claims that are submitted by doctors and suppliers under Medicare.
- **Coinsurance** — The portion of Medicare's approved amount that the beneficiary is responsible for paying.
- **Comprehensive Outpatient Rehabilitation Facility Services** — Outpatient services received from a Medicare participating comprehensive outpatient rehabilitation facility.

- **Deductible** — The amount of expense a beneficiary must first incur before Medicare begins payment for covered services.
- **Durable Medical Equipment** — Medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that a doctor prescribes for use in the home.
- **Excess Charge** — The difference between the Medicare-approved amount for a service or supply and the actual charge.
- **Intermediaries** — Organizations that process inpatient and outpatient claims on individuals by hospitals, skilled nursing facilities, home health agencies, hospices and certain other providers of health services.
- **Limiting Charge** — The maximum amount a physician may charge a Medicare beneficiary for a covered service if the physician does not accept assignment.
- **Nonparticipating** — Doctors or suppliers who may choose whether or not to accept assignment on each individual claim.
- **Outpatient Physical and Occupational Therapy and Speech Pathology Services** — Medically necessary outpatient physical and occupational therapy or speech pathology services prescribed by a doctor or therapist.
- **Pap Smear Screening** — Provides for a pap smear to screen for cervical cancer once every 2 years.
- **Partial Hospitalization for Mental Health Treatment** — A program of outpatient mental health care.
- **Participating Doctor or Suppliers** — Doctors and suppliers who sign agreements to become Medicare-participating. *For example*, they have agreed in advance to accept assignment on all Medicare claims.
- **Peer Review Organizations** — Groups of practicing doctors and other health care professionals who are paid by the government to review the care given to Medicare patients.

Medicare Part B: Medical Insurance Covered Services

Reference Chart

BENEFITS	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSES:		
Medicare pays for medical services in or out of the hospital	80% of approved amount after the deductible	Deductible*, plus 20% of approved amount and limited charges above approved amount
CLINICAL LABORATORY SERVICES:		
Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
HOME HEALTH CARE:		
For as long as you meet Medicare requirements for home health care benefits	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT:		
Unlimited if medically necessary	Medicare payment to hospital based on hospital cost	20% of billed amount after the deductible
BLOOD:		
Unlimited if medically necessary	80% of approved amount after the deductible, and starting with 4th pint	First 3 pints plus 20% of approved amount for additional pints after the deductible**

** Once you have reached a specified dollar amount in expenses for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.*

*** To the extent that any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year. They do not have to be paid for or replaced under the other part.*

6. Part C - Medicare Advantage

Educational Objective:

III.D.1.f. For Medicare Part C (Medicare Advantage), be able to describe the managed care aspects of the coverage provided by health care organizations:

i. HMO and PPO models
ii. Private Fee-for-Service plans (PFFS)
iii. Special Needs Plans (SNP)
iv. Know that enrollment in a stand-alone prescription drug plan (PDP) automatically terminates enrollment in a Medicare Advantage plan
v. Coverage

The Medicare Modernization Act of 2003 changed the name of **Part C** from Medicare+Choice to **Medicare Advantage**. Medicare Advantage plans must cover all of the services covered under the Original Medicare except hospice care and some care in qualifying clinical research studies. However, Part C plans may have lower out-of-pocket costs than Original Medicare. They may also offer extra coverage, such as vision, hearing, dental, and other health and wellness programs.

To be **eligible** for Medicare Advantage, beneficiaries must also be enrolled in Medicare Parts A and B. Medicare Advantage is Medicare provided by an approved Health Maintenance Organization or Preferred Provider Organization. Many HMOs or PPOs do not charge premiums beyond what is paid by Medicare. The advantages of an HMO or PPO for a Medicare recipient may be that there are no claims forms required, almost any medical problem is covered for a set fee so health care costs can be budgeted, and the HMO or PPO may pay for services not usually covered by Medicare or Medicare supplement policies, such as prescriptions, eye exams, hearing aids, or dental care.

Most Medicare HMOs require that medical services be received through the plan, except in emergencies. A few allow greater freedom of choice through point-of-service plans.

A Medicare **Private Fee-for-Service Plan** is a Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money every month to the private insurance company to provide health care coverage. The insurance company decides how much enrollees pay for the services they get.

Another section of Medicare Advantage Plan (Part C), **Special Needs Plans**, provides more focused and specialized health care for specific groups of people. This includes people who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Know This! Medicare Part C expands Original Medicare benefits through private health insurance programs.

7. Part D - Prescription Drug Benefit

Educational Objective:

III.D.1.g. For Medicare Part D, be able to identify:

i. Enrollment is optional
ii. Premiums, deductibles, and copayments
iii. Enrollment periods
iv. That PDPs may be purchased as stand-alone plans or embedded within Medicare Advantage plans (MAPD)
v. That a beneficiary may enroll in a PDP if enrolled in Part A and/or Part B
vi. The coverage periods
vii. That insurance companies must create and annually file a formulary

The **Medicare Prescription Drug, Improvement, and Modernization Act of 2003** (MMA) was passed in November 2003. This act implemented a plan to add a **Part D -** Prescription Drug Benefit to the standard Medicare Coverages. This **optional coverage** is provided through private prescription drug plans (PDPs) that contract with Medicare. To receive the benefits provided, beneficiaries must sign up with a plan offering this coverage in their area and must be enrolled in Medicare Part A or in Parts A and B. In areas where no private plans are offered, the government will offer a standard plan. Medicaid recipients are automatically enrolled.

If Medicare beneficiaries don't enroll when they are first eligible, they must pay a 1% penalty for each month they delayed enrollment.

Medicare beneficiaries may choose between **stand-alone plans** that offer coverage on a fee-for-service basis, or **integrated plans** that group coverages together, including PPOs and HMOs (known as Medicare Advantage).

The plans offered by private companies are restricted by some standards set by Medicare, but still have freedom to personalize their plans. Providers must cover drugs for certain classes, but do not have to cover every drug in each class.

Those who sign up for the standard Prescription Drug Benefit plan will have a monthly premium and a deductible. The monthly premium varies by plan. After the deductible is paid, the plan would provide prescription drug costs coverage until a benefit limit is reached. Once the beneficiary and their plan spend $4,660 combined on drugs (including deductible), the beneficiary will generally pay no more than 25% of the cost for prescription drugs until their out-of-pocket spending is $7,400 (for 2023), under the standard drug benefit.

Once the beneficiary has reached their out-of-pocket spending, **catastrophic coverage** begins automatically. Catastrophic coverage will cover 95% of prescription drug costs. In most cases, the beneficiary will pay no more than 5% of the cost for covered drugs for the rest of the year.

Additional assistance will be available for those with low income. There will be no gap in coverage for these beneficiaries.

Know This! After the initial benefit limit is reached, a Prescription Drug Benefit plan will pay 75% of all generic and brand name drug costs.

The term *creditable coverage* means health coverage that an individual had in the past that gives him or her certain rights when applying for new coverage. Creditable coverage **includes,** but is not limited to, any of the followings:

- Coverage provided under any individual or group policy or certificate issued or administered by any health care service plan, insurer or entity;
- Coverage under Medicare Parts A or B, and Medicaid;
- Coverage under a state health benefits risk pool; or
- Health plans under the Federal Employees Health Benefits Program.

Creditable coverage **does not include:**

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Workers compensation;
- Credit-only insurance; or
- Other similar insurance in which benefits for medical care are secondary or incidental to other insurance benefits.

Medicare supplemental health insurance offered as a separate policy would not be considered creditable coverage.

Creditable prescription drug coverage is coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage. Individuals who have creditable prescription drug coverage when they become eligible for Medicare can usually keep that coverage without paying a penalty if they decide to enroll in Medicare Part D later.

Individuals will not have to pay a penalty if they do any of the following:

- Join a Medicare Part D when first eligible;
- Have no more than 63 days without a Medicare drug plan or other creditable coverage; or
- Let the Medicare plan know if you have other creditable coverage.

Formularies

As defined by Medicare, **a formulary** is a list of prescription drugs covered by a prescription drug plan, also known as a *drug list*. Each plan has its own formulary that must be filed annually. Whenever the plan makes changes to the formulary, the insureds must be notified. Medicare drug plans categorize drugs into different tiers, each with a different cost. Drugs in a lower tier will cost less than drugs in a higher tier. A formulary must include at least 2 drugs in each treatment category, but it is not required to include all drugs.

Know This! Formulary = drug list; must have at least 2 drugs in each treatment category

8. Medicare Claims Payments

Educational Objective:

III.D.1.h. Be able to identify how Medicare claims payments are handled in the Original Medicare fee-for-service program:

i. How Medicare claims are submitted by health care providers and approved medical equipment suppliers to Centers for Medicare and Medicaid Services (CMS)
ii. Medicare assignment vs. non-assignment
iii. What information provided in a Medicare Summary Notice
iv. Common coverages and exclusions
v. When a beneficiary has the right of appeal and how an appeal is processed

How Medicare Claims are Submitted

If the insured's health care provider accepts Medicare assignments, the insured pays his/her portion of the bill (coinsurance, deductibles). The health care provider will file a Medicare claim. Medicare then pays its portion of the bill directly to the provider.

If a health care provider does not accept Medicare assignments, the insured may have to pay most of or the entire bill at the time service is rendered. The provider is still required to file a Medicare claim on the insured's behalf. Medicare would then pay its share of the bill to the insured.

If a health care provider does not file a claim on behalf of the insured, the insured may take the following steps:

- Call the health provider directly and ask to have a claim filed;
- If the provider still does not file a Medicare claim after talking to the insured, the insured may call his/her local Medicare Carrier. The Medicare Carrier will contact the health care provider to make him/her aware of the responsibility for filing a claim.
- An insured should only need to file a Medicare claim in rare situations. To file a Medicare claim, the insured should call his/her local Medicare Carrier and ask for the proper form for a Medicare beneficiary to file a claim.

Explanation of Medical Benefits

When a claim is processed by Medicare, the claimant is mailed an Explanation of Medicare Benefits which outlines specific services covered and the amounts approved for each, and includes the following information:

- Date that the explanation was sent;
- Who to contact with questions;
- Claimant's Medicare card number;
- Name and address of the claimant;
- Part B Medical Insurance- Assigned claims;
- Claim number;
- Provider's name and address;
- Date of service;
- Amount charged;
- Medicare approved amount;
- Medicare paid provider; and
- Amount the claimant may be billed by the provider.

Medicare Assignment and Non-assignment Providers

If a Medicare insured uses a health care provider who doesn't accept Medicare payments, he or she may be asked to sign a private contract. A **private contract** is a written agreement between the Medicare insured and the health care provider who has decided not to participate in the Medicare program. The private contract only applies to the services that the insured gets from that provider. The insured can't be asked to sign a private contract in an emergency situation or when the insured gets urgently-needed care.

The following conditions will apply if the insured signs a private contract with the provider:

- The insured will have to pay whatever the provider charges for the services. Medicare limiting charges will not apply;
- No claim should be submitted to Medicare, and Medicare will not pay if one is submitted;
- The insured's Medicare supplement policy (if any) will not pay anything for this service;
- Medicare health plans will not pay any amount for the services received from this provider;
- The provider must tell the insured whether Medicare would pay for the service if it was received from another provider who participates in Medicare; and
- The provider must tell the insured if he or she has opted out of or been excluded from the Medicare program.

Medicare-insured individuals should talk to someone in the State Health Insurance Assistance Program before signing a private contract.

Medicare Summary Notice

The **Medicare Summary Notice** (MSN) is a monthly statement that lists the insured's health insurance claims information, specific services covered, and the amounts approved for each service.

Insured's Right to Appeal

The insured has the right to appeal any decision about his/her Medicare services. If Medicare does not pay for an item or service an insured has been given, the insured may appeal that decision. The insured may also appeal if he/she does not receive an item or service he/she thinks should be given to him/her.

Exclusions

The following expenses are not covered by Medicare:

- Acupuncture;
- Deductibles, coinsurance, or copayments for health care services;
- Dental care and dentures (in most cases);
- Most chiropractic services;
- Cosmetic surgery;
- Custodial care (help with bathing, dressing, using the bathroom, eating), unless skilled nursing care is provided at the same time, at home or in a nursing home;
- Health care received outside the United States (coverage is limited for Canada and Mexico);
- Hearing aids and exams;

- Orthopedic shoes;
- Most prescription drugs;
- Routine foot care (with a few exceptions);
- Routine eye care and most eyeglasses (except after cataract surgery);
- Immunizations (except for flu and pneumonia shots);
- Private duty nursing; and
- The first 3 pints of blood received during one calendar year.

B. Medicare Supplement Policies

Educational Objective:

III.D.1.e. Regarding Medicare Supplement Insurance, be able to identify:

i. The federally standardized Medicare supplement policies and the gaps in Medicare coverage they are designed to fill:
1). Basic (or "core") benefits of Plan A are applicable to all plans
2). The additional benefits included in plans B, C, D, F (including high-
deductible and innovative options), G, K, L, M and N
ii. CIC requirements regarding benefits required in each standardized plan (CIC 10192.8) and Medicare SELECT plans (CIC 10192.10)

Medicare Supplement plans, referred to as **Medigap,** are policies issued by private insurance companies that are designed to fill in some of the gaps in Medicare. These plans are designed to fill the *gap* in coverage attributable to Medicare's deductibles, copayment requirements, and benefit periods. These plans are not administered through the federal Social Security program, as is Medicare, but instead are sold and serviced by private insurers and HMOs. These policies must meet certain requirements and must be approved by the state department of insurance. Medicare Supplement policies pay some or all of Medicare's deductibles and copayments.

Under the Omnibus Budget Reconciliation Act of 1990 (**OBRA**), Congress passed a law that authorized the NAIC to develop a standardized model for Medicare supplement policies. This model requires Medigap plans to meet certain requirements as to participant eligibility and the benefits provided. The purpose of this law was to eliminate questionable marketing practices and to provide consumers with a degree of protection and to standardize the protection afforded.

Know This! Medicare supplement plans are sold through private insurers, not federal health insurance programs.

1. Standard Medicare Supplement Plans

Educational Objective:

III.D.1.i. Be able to identify the standardized Medicare Supplement policies and how they are designed to fill the gaps of Medicare

coverage.

In order to standardize the coverage provided under Medicare supplement policies, the NAIC has developed standard Medicare Supplement benefit plans which are identified with the letters A through N. **The core benefits found in Plan A must be offered in all the plans**, and the other plans have a variety of additional benefits. Plan A must be offered by any insurer marketing Medigap plans, while the other plans are optional.

Once a person becomes eligible for Medicare supplement plans, and during the open enrollment period, coverage is offered on a guaranteed issue basis. In these situations, an insurance company must do the following:

- Sell the patient a Medicare supplement policy;
- Cover all pre-existing conditions incurred more than 6 months from effective date of coverage; and
- Not charge more for a supplement policy because of past or present health problems.

The California Insurance Code (10194.2-.3) requires Medicare Supplement Plans A-N benefits as listed below.

Know that insurers offering Medicare Supplement policies must offer Medicare Supplement Plan A, and either Plan C or F.

2. Plan A - Core Package of Benefits

Medicare Supplement Plan A provides only the **core benefits**. The core benefits, also known as basic benefits, cover the following:

- Part A coinsurance/copayment *(NOT Part A deductible);*
- Part A hospital costs up to an additional 365 days after Medicare benefits are used up;
- Part A hospice care coinsurance/copayment;
- Part B coinsurance/copayment; and
- The first 3 pints of blood ("blood deductible" for Parts A and B).

3. Plans B - N

In addition to Plan A, which offers only the core benefits, most insurers also offer some or all of the additional plans. Insurers are not allowed to change the benefits offered in these supplemental plans, nor may they change the designation letter of any of the plans.

Plan B – Core benefits plus Medicare Part A deductible.

Plan D – Core benefits, Medicare Part A deductible, skilled nursing facility coinsurance, and the foreign travel benefit.

Plan G – Core benefits, Medicare Part A deductible, skilled nursing facility coinsurance, 100% of Medicare Part B excess charges, and the foreign travel benefit. This plan must pay for services of activities of daily living (ADL) that Medicare doesn't cover.

Plans C, E, F, H, I and J are no longer available. These plans will remain in force for those insureds who purchased them when they were still available.

Medicare Supplement **Plans K and L** are lower premium plans with higher out-of-pocket costs. The core benefits are different in these 2 plans as well:

- Approved hospital costs for the copayments for days 61 through 90 in any Medicare benefit period.
- Approved hospital costs for the copayments for lifetime reserve days 91 through 150.
- Approved hospital costs for an additional 365 days after all Medicare benefits are used.
- 50% of charges for the first 3 pints of blood in Plan K, 75% of charges for the first 3 pints of blood in Plan L.
- 50% of Part B coinsurance amount in Plan K, 75% of Part B coinsurance amount in Plan L.
- 50% of hospice cost-sharing and respite care expenses for Part A in Plan K, 75% of hospice cost-sharing and respite care expenses for Part A in Plan L.

Plan K includes 50% of the Medicare Part A deductible and 50% of skilled nursing facility coinsurance.

Plan L includes 75% of the Medicare Part A deductible and 75% of skilled nursing facility coinsurance.

Plans M and N provide benefits similar to Plan D, but the co-pays and deductibles might be different.

This table outlines the benefits provided under each of the Medigap plans available.

	Basic Benefit	Skilled Nursing Coin.	Part A Deduct.	Part B Excess (100%)	Foreign Travel Emer.
A					
B					
D					
G					
K		50%	50%		
L		75%	75%		
M			50%		
N					

Know This! All Medicare supplement plans must offer the core benefits available in Plan A.

4. Medigap Requirements

Other Requirements — Insurers are required to use the same format, language, and definitions in describing the benefits available in each of the Medigap plans. They are required to use a standardized chart and outline that summarizes the benefits.

Although insurers are not allowed to alter the standardized benefits offered in each of these plans, they are allowed to offer new, innovative benefits which can be proven cost-effective and which are not currently available in the marketplace.

All Medigap policies are **guaranteed renewable**. The insurance company cannot cancel or nonrenew coverage except for nonpayment of the premium or because of material misrepresentation on the application. In addition, although the benefits provided by these plans are identical from one company to the next, the premiums vary greatly. Depending on how the insurer determines the premium charge, they can usually increase premiums on the policy anniversary date. Medigap policies must also include a **30-day free-look** provision that allows the

insured to return the policy to the insurer within 30 days for a full refund of the premium paid.

Medigap policies cannot include a provision that restricts coverage for pre-existing conditions for more than 6 months. In addition, if the insured has had a Medigap policy for at least 6 months and decides to change to another policy, the new policy cannot have a waiting period for pre-existing conditions for the same coverage that was included in the old policy. If the replacement policy includes additional coverage that was not in the old policy, then the 6-month waiting period can be applied, but only as it pertains to the additional coverages.

5. Replacement Coverage

Every insurance company's application for Medicare Supplement insurance must contain a question designed to determine if the applicant has another Medicare Supplement policy or if this policy will replace any other accident and health policy. The application must also ask if the applicant is eligible for Medicaid and advise the applicant that counseling services may be available. It is the responsibility of the issuers, brokers and agents to ensure that Medicare Supplement policies are not being unnecessarily replaced.

If replacement is involved, the insurance company or its agent must furnish the applicant with the "**Notice Regarding Replacement**" before issuing or delivering the policy. The insurance company must retain one copy, signed by the applicant and the agent. The "Notice Regarding Replacement" must inform the applicant of the **30-day free-look** provision of the policy.

If a Medicare supplement policy replaces another, the replacing insurance company must waive any time periods on pre-existing conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy to the extent that these time periods were met under the policy being replaced. If a Medicare Supplement policy replaces another that has been in effect for **6 months** or more, the replacing policy may not have any time requirement on pre-existing conditions, waiting periods, elimination periods, or probationary periods for the benefits similar to those contained in the original policy.

In order to avoid abuses, Medicare supplement policies issued in California (CIC 10197) must meet the following rules regarding replacement and solicitation:

- No insurer, broker, agent, or other person may cause a policyholder to replace a Medicare supplement policy unnecessarily when it will result in a decrease in benefits and an increase in premium;
- Medicare supplement application forms must include questions that ask whether the applicant has another Medicare supplement policy in force, or whether the proposed supplement policy is intended to replace any other disability policy;
- Each agent must list any other disability policies that the agent or his or her agency has sold to the applicant, including those still in force and those sold in the past 5 years that are no longer in force; and
- When a sale does involve replacement, the insurer (other than a direct response insurer), must give the applicant a notice regarding replacement of disability coverage. This notice must be given before the replacing policy is issued or delivered. A copy of the notice, signed by the applicant and agent, must be provided to the applicant. The insurer must keep an additional copy. A direct

response insurer, which does not have sales agents, must nonetheless deliver a similar notice regarding replacement upon policy issuance.

6. Medicare SELECT

A Medicare SELECT policy is a Medicare supplement policy that contains restricted network provisions — provisions that condition the payment of benefits, in whole or in part, on the use of **network providers**. SELECT plans negotiate with a provider network of doctors, hospitals and specialist to charge lower rates for medical services. It essentially operates like an HMO. These lower rates keep costs down for the SELECT plan provider, and plan members pay lower premiums.

Each Medicare SELECT policy must be approved by the head of a state's department of insurance. Currently, issuers are not allowed to sell new Medicare SELECT policies to individuals whose primary residence is located outside of the issuer's service area.

Every Medicare SELECT policy must do the following:

- Provide payment for full coverage under the policy for covered services not available through network providers;
- Not restrict payment for covered services provided by non-network providers if the services are for symptoms requiring emergency care and it is not reasonable to obtain such services through a network provider;
- Make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare SELECT policy to each applicant;
- Make available upon request the opportunity to purchase a Medicare supplement policy offered by the issuer which has comparable benefits and does not contain a restricted network provision. These policies must be available without requiring evidence of insurability if the Medicare SELECT policy has been in force for 6 months; and
- Provide for continuation of coverage in the event that Medicare SELECT policies are discontinued due to the failure of the Medicare SELECT program.

7. Medicare Disclosure Requirements

Educational Objective:

III.D.1.e.iii. Be able to identify the Medicare disclosure requirements for:

a. Outline of coverage (CIC 10192.17(l)(3)(G))
b. Application (CIC 10192.18(a)(6))
c. Replacement (CIC 10192.18(e))
d. Commissioner's Annual Rate Guide (CIC 10192.20(e)(4))

Outline of Coverage

The **outline of coverage** provided with Medicare supplement policies must be in the language and format prescribed by the California Insurance Code, be in at least 12-point type, and include the following disclosures:

- *This policy may not fully cover all of your medical costs.*
- *Neither this company nor any of its agents are connected with Medicare.*
- *This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult The Medicare Handbook for more details.*
- *For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent (phone number must be included).*

Application

Application forms used for Medicare supplement policies must include questions designed to elicit information as to whether as of the date of the application the applicant has current Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy in force, or whether a Medicare supplement policy is intended to replace any other disability policy in force.

Replacement

The Notice Regarding Replacement must be provided to the insureds with Medicare supplement policies offered in a replacement transaction. The notice must be in the form specified by the Commissioner using a model notice prepared by the National Association of Insurance Commissioners (NAIC), and must be printed in no less than 12-point type in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

"If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT. If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money."

Commissioner's Annual Rate Guide

The Commissioner of Insurance prepares an annual consumer rate guide for Medicare supplement insurance and Medicare supplement contracts, on or before the date of the fall Medical annual open enrollment. The guide compares policies sold by different insurers. The guide must be available through Health Insurance Counseling and Advocacy Program (HICAP) offices; by telephone, using the department's consumer toll-free telephone number, and on the department's Internet website.

C. Medi-Cal

Educational Objective:

III.D.1.f.iii. Be able to identify what Medi-Cal is and who is eligible, including those with a share of cost.

As persons grow older, their need for health care or other services related to aging becomes more demanding. Statistically, the majority of a person's health care expenses will be incurred in the last five years of life. For most individuals, this means at later ages. In the past 20 years, due in large part to dramatic advances in technology and pharmaceuticals, the cost of medical care, especially later in life, has risen significantly in the United States.

In 2002, there were more than 40 million persons who had no medical insurance of any kind, and one study asserted that over the course of the year, some 70 million persons were without medical insurance for at least one day. For many of these persons, the federally-funded Medicaid program is available to cover some of their needs. Medicaid is a federal-state partnership in which the federal government pays for the majority of medical claims, while the states are responsible for their own administrative expenses. Each state is given the flexibility to determine what will be covered, within federal guidelines, so that the program is most beneficial for the residents of their state.

In California, the program is known as **Medi-Cal**, but it is still largely funded with federal reimbursements. Medi-Cal is free or low-cost coverage for adults and children with limited income and resources.

1. Eligibility

California residents in a variety of situations may qualify for benefits from Medi-Cal; however, individuals who receive cash assistance from one of the following programs are automatically eligible for Medi-Cal:

- SSI/SSP (Supplemental Security Income/State Supplemental Program);
- CalWORKS (CA Work Opportunity and Responsibility to Kids);
- Refugee Assistance; and/or
- Foster Care or Adoption Assistance Program.

Other categories of individuals that may be eligible for Medi-Cal are listed below:

- Persons over age 65;
- Blind and other disabled persons of any age;
- Children in foster care up to age 26; and/or
- Pregnant women or women diagnosed with breast or cervical cancer.

For most persons, Medi-Cal operates as, or contracts with, an HMO to provide services and care for recipients.

In order to qualify for long-term care benefits under Medi-Cal, there is a specific **asset spend-down test** which must be met monthly in order to qualify for benefits. The amounts are readjusted annually, and currently a person needing long term care **cannot** have **countable** assets in excess of about $3,000. If the person is married, he/she will still not qualify for Medi-Cal benefits until his/her spouse's countable assets fall below about $90,000. These rules are in place to prevent persons from using the resources of the state instead of using their own assets. The spend-down can result in a surviving spouse living near poverty as the result

of having to dispose of a large share of his/her assets in order for his/her spouse to receive Medi-Cal benefits.

If an individual's income exceeds the Medi-Cal limit for his/her family size, that individual will have to pay a certain amount, called **share of cost** (SOC), in the month when medical expenses occurred. Once the SOC has been met, Medi-Cal will pay the rest of the covered medical bills for that month.

Benefits provided by Medi-Cal need to be understood, particularly when it comes to long term care as a "no interest" loan. When a person dies, the state may exercise its right to pursue **asset recovery** from the estate of a Medi-Cal recipient up to the full value of the benefits that were paid for by the state. This could result, after death, in the seizure of a person's home or business property, which were not part of their "countable assets," in order to reimburse the state for its expenditures. Even though these possessions may have been intended to be transferred to children or other heirs, the state may have a priority claim over all others.

In 2014, Medi-Cal eligibility has been **expanded to include the nondisabled, nonelderly, childless adults up to 138% FPL.** Households income is calculated using Modified Adjusted Gross Income (MAGI), based on the household's income tax returns with adjustments. There is no asset test for MAGI households.

In addition, to qualify for Medi-Cal coverage under the **Adult Expansion Medi-Cal program**, individuals:

- Must be between the ages of 19 and 64;
- May not be pregnant;
- Do not get Medicare; and
- Do not have Medi-Cal without a Share of Cost already.

Medi-Cal coverage may be available to children under age 19 if their household's income is no more than 250% of the FPL.

D. Medicare And Medi-Cal

Dual eligible beneficiaries are those who qualify for both Medicare and Medi-Cal benefits. Based on the level of benefit received from Medi-Cal, dual eligible enrollees may be categorized as follows:

- **Full benefit enrollees** who receive full Medi-Cal benefits available in the state; or
- **Partial benefit enrollees** who receive Medi-Cal assistance to pay Medicare premiums and/or other cost-sharing obligations.

A Medicare Advantage Dual Eligible Special Needs Plan provides an integrated Medicare/Medi-Cal option for full benefit enrollees who are ages 65 and older, and living in the plan's service area.

1. California Insurance Code Requirements

Standardized Plan Benefits

Each standardized plan must meet the following requirements for plan benefits:

- The plan may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage due to a pre-existing condition.
- Losses from sickness must be indemnified on the same basis as losses from accidents.
- Benefits that cover cost-sharing amounts under Medicare will be automatically changed to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors.
- Coverage for a spouse cannot be terminated solely because of the event that terminates coverage of the insured (except for nonpayment of premium).
- Medicare supplement policies must be guaranteed renewable or noncancelable.

Open Enrollment

There are several regulations concerning open enrollment period for Medicare supplement plans*:*

- *Disabled individuals* enrolled in Medicare must be entitled to open enrollment for **6 months** after the date of the enrollment or after the notice of eligibility for Medicare.
- Individuals *enrolled in Medicare Part B* may also be entitled to open enrollment for **6 months** following the events listed below:
  - Receipt of a notice of termination of an employer-sponsored health plan;
  - Receipt of a notice of loss or eligibility for an employer-sponsored health plan due to the divorce or death of a spouse;
  - Termination of health care services for a military retiree due to a military base closure or termination of health services coverage.
- An individual whose *Medicare Advantage plan coverage was terminated* is entitled to an **additional 60-day open enrollment period**.
- An annual open enrollment period of **30 days** or more (beginning with the individual's birthday), during which the individual may purchase any Medicare supplement policy with benefits of equal or lesser value than those provided by the previous coverage.
- Individuals enrolled in Medicare Part B are entitled to open enrollment period once they have been notified that they are no longer eligible for benefits under the Medi-Cal program due to an increase in their income or assets. *(CIC 10192.11)*

Guaranteed Issue Periods

In general, the guaranteed issue period begins on the effective date of disenrollment and ends 63 days after the effective date of disenrollment. In some circumstances involving voluntary disenrollment, coverage will begin 60 days prior to the effective date of the disenrollment and will continue for 63 days after the effective date of the disenrollment.

Permitted Commissions

An agent or other representative that is involved in the sale of Medicare supplement policies may receive commissions as long as the 1st-year commission does not exceed 200% of the commissions paid for selling or servicing the policy in the 2nd year. Commissions in subsequent renewal years must be the same as in the second year and must be provided for no fewer than 5 renewal years. The term *commission* refers to any monetary and non-monetary compensation, including bonuses, gifts, prizes, awards and finders' fees. *(CIC 10192.16)*

Appropriate Sales and Replacement

In order to comply with the California Insurance Code regulations regarding sales and replacement of Medicare supplement policies *(CIC 10192.20),* the insurer must meet each of the following requirements:

- Establish marketing procedures for fair and accurate comparison of policies by its agents, and to prevent excessive sales of insurance;
- Prominently display a notice to buyer on the first page of a policy stating that the policy may not cover all of the buyer's medical expenses;
- Make every reasonable attempt to identify whether a prospective applicant already has health insurance; and
- Establish auditable procedures for verifying compliance with the Code regulations.

Insurers may not participate in any of the unfair trade practices, such as twisting, high pressure tactics or cold lead advertising (concealing from the customer that the purpose of marketing is the solicitation of insurance).

Any agent selling a Medicare Supplement must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. The application for Medicare Supplement insurance must include a statement signed by the agent that read as follows: *"I have reviewed the current health insurance coverage of the applicant and found that additional coverage of the type and amount applied for is appropriate for the applicant's needs."*

Any sale of a Medicare Supplement policy that would give the insured **more than one such policy is prohibited.**

Medicare Advantage is **not** a Medicare Supplement plan and does **not coordinate** with Medicare Supplement plans.

Prohibitions on Discrimination

The act of treating any person or group of persons unfairly in the sale of or pricing of policies or the act of treating any class of risk differently from other classes of risk is expressly prohibited by California law (CIC 10194.8).

E. Health Insurance And Counseling Advocacy Program (HICAP)

Educational Objective:

III.D.2. For HICAP, be able to identify that HICAP is a federally mandated, state and federally funded program that provides free assistance to Medicare beneficiaries and their families concerning Medicare, Medicare Advantage, Medicare Supplement Insurance, Prescription Drug Plans, Medi-Cal, and Long-Term Care Insurance:

i. The educational services, consumer advocacy, and legal assistance provided
ii. The program is administered by the Department of Aging and

operated locally by Area Agencies on Aging
iii. Assistance by phone or in person, as well as legal assistance

1. Who the Program Serves

The state Department of Aging is responsible for overseeing the **Health Insurance Counseling and Advocacy Program (HICAP)** — a federally mandated and state and federally funded program. In conjunction with local Area Agencies on Aging operated in each county in California, HICAP provides free assistance to seniors who are already receiving or are about to receive Medicare or Social Security benefits. HICAP provides consumer counseling related to the purchase of health insurance, long-term care insurance, Medicare, Medicare Advantage, Medicare supplement, or Medi-Cal insurance.

2. Cost of Program to Persons Served

Funding for HICAP is provided by the state and local governments, principally with state and local revenue and, to a lesser extent, with federal funds, and all services are provided without cost to clients. HICAP agencies do not sell, recommend, or in any other way transact insurance.

3. Function of Program

HICAP fulfills the following functions:

- **Free assistance:** the program provides free individual counseling about Medicare and other health care issues. Counseling is available in every county in California. The majority of HICAP counselors are trained and certified volunteers.
- **Education:** free educational presentations are available to groups of Medicare beneficiaries, their families and providers.
- **Consumer advocacy:** the program handles complaints about abusive practices of agents or insurers, referring them, when appropriate, to state or local enforcement agencies for investigation of crimes such as twisting, misrepresentation, or financial abuse.
- **Legal assistance:** HICAP counselors provide help with Medicare claims, appeals, denials, or delays of service or treatment. Their responsibility is also to give customers unbiased advice about Medicare Advantage plans, supplemental insurance, and long-term care, among other issues.

4. How to Locate a Program

A list of local HICAPs for each county in California is provided through www.calmedicare.org, a **Medicare information website** approved by the Department, which gives accurate and unbiased information about Medicare benefits for residents of California. Contact information for the local HICAP agencies can also be found at http://www.aging.ca.gov/hicap/countyList.aspx. The website also provides the **statewide toll-free phone number** available to anybody seeking help or free counseling on Medicare or other health care issues (800-434-0222).

F. Chapter Recap

This chapter explained health insurance available to senior citizens and special needs individuals: Medicare, Medicare Supplements, and Medicaid. Let's recap some of the key points:

MEDICARE

Basics

- Federal medical expense insurance program for people who:
  - Are age 65 or older
  - Have been entitled to Social Security disability income benefits for 2 years
  - Have a permanent kidney failure (ESRD)
- 4 parts:
  - *Part A, Hospital Insurance*, financed through payroll tax (FICA)
  - *Part B, Medical Insurance*, financed by insureds and general revenues
  - *Part C, Medicare Advantage*, allows for receipt of health care services through available provider organizations
  - *Part D, Prescription Drug* coverage

Part A

- Enrollment:
  - *Initial enrollment period* - when an individual first becomes eligible for Medicare (starting 3 months before turning age 65, ending 3 months after the 65th birthday)
  - *General enrollment period* - between January 1st and March 31st each year
  - *Special enrollment period* - at any time during the year if the individual or his/her spouse is still employed and covered under a group health plan
- Coverage:
  - Inpatient Hospital Care
  - Skilled Nursing Facility Care
  - Home Health Care
  - Hospice Care

Part B

- Optional; offered to everyone who enrolls in Part A
- Coverage:
  - Doctor Services
  - Outpatient Hospital Services
  - Home Health Visits
  - Other Medical and Health Services
  - Prescription Drugs (limited coverage)
  - Outpatient Treatment of Mental Illness
  - Yearly wellness visit

Part C

- Medicare Advantage: requires enrollment in Parts A and B
- Provided by an approved Health Maintenance Organization or Preferred Provider Organization

Part D

- Prescription drug benefit
- Optional coverage through private prescription plans that contract with Medicare

Primary, Secondary Payor	For individuals eligible for Medicare coverage who continue to work, the employer's health plan would be primary coverage while Medicare would be secondary coverage

MEDICARE SUPPLEMENT POLICIES

Basics	• Referred to as Medigap • Policies issued by private insurance companies to fill in gaps in Medicare • Open enrollment period of 6-months
Coverage	• Plan A: core benefits, such as coinsurance/copayment; additional Part A hospital costs; hospice care coinsurance / copayment; Part B coinsurance/copayment; 3 pints of blood under Parts A and B • Plans B – N: core benefits + various additional benefits

OTHER OPTIONS FOR INDIVIDUALS WITH MEDICARE

Medi-Cal	• Medical care for those whose income and resources are insufficient • Federal and state funded • Eligibility determined by asset spend-down test • Full benefit enrollment - assistance to pay for Medicare premiums/cost sharing obligations • Not a Medicare Supplement plan
Health Insurance and Counseling Advocacy Program (HICAP)	• Consumer counseling for those who receive Social Security or Medicare coverage • Federal and state funded • Does not sell, recommend, or transact insurance