Insurance For Senior Citizens & Special Needs Individuals

This chapter will discuss social insurance and its government-sponsored programs of Medicare and Medicaid. By the end of this chapter, you should be able to explain eligibility requirements, basic benefits, and services provided by these programs. This section is full of medical terms, acronyms, and numbers. Note that the dollar amounts of different types of Medicare deductibles change frequently, and are provided as a reference only. What's important for you to remember is who qualifies for each type of plan, and what type of coverage they can expect. This section will also cover long-term care policies, including benefits, exclusions, and state-specific requirements.

TERMS TO KNOW

Attained age — the insured's age at the time the policy is issued or renewed
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
Nonforfeiture benefit — a cash or insurance benefit received by a policyholder who no longer wishes to make payments after making premium payments for at least the minimum period
Outline of coverage — a document required in all health insurance policies that provides a full coverage disclosure to the applicant

A. Medicare

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 a 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.

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. Part A - Hospital Insurance

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.

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.

Medicare Part A: Hospital Insurance Covered Service
Reference Chart

BENEFITSMEDICARE PAYSYOU PAY

HOSPITALIZATION:

First 60 daysAll but the deductibleDeductible

Days 61-90All but daily deductibleDaily 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.*

3. Part B - Medical Insurance

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.

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.*

4. Part C – Medicare Advantage

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.

5. Part D - Prescription Drug Insurance

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.

6. Primary, Secondary Payor

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.

B. Medicare Supplements

1. Purpose

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.

2. Open Enrollment

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.

3. Standardized Medicare Supplement Plans

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.

Core 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).

Additional Benefits

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. 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.

5. Pennsylvania Regulations and Required Provisions

Standards for Marketing and Advertising

The following are standards for marketing Medicare supplement policies:

- Every insurance company must establish marketing procedures to assure that any comparison of policies by their agents will be fair and accurate;
- Insurance companies must have marketing guidelines to assure that excessive amounts of insurance are not sold or issued;
- There must be established a formula to determine whether a replacement policy contains benefits clearly and substantially greater than those under the policy being replaced; and
- The first page of the policy must contain the *"Notice to buyer: This policy may not cover all of your medical expenses."*

Insurance companies must make every reasonable effort to determine whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the type and amounts that they currently own. The insurance company must establish procedures to verify that they are complying with these rules.

Twisting, high-pressure tactics, and misleading advertising may not be utilized. The terms *Medicare Supplement, Medigap, Medicare Wrap-Around* and similar words may not be used unless the policy is in full compliance of the law.

An insurance company must provide a copy of any Medicare Supplement advertisement intended to be used in this state to the Insurance Commissioner for review or approval.

Appropriateness of Recommended Purchase and Excessive Insurance

When selling a Medicare supplement policy, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

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

Insurers cannot issue Medicare supplement policies to individuals enrolled in Medicare Part C unless the effective date of the coverage is *after* the

termination date of Part C coverage.

Replacement

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.

Please note that if an insured becomes eligible for Medicaid after purchasing a Medicare supplement policy, that policy's benefits and premiums may be suspended for up to **24 months**. A suspension must be requested within **90 days** of Medicaid eligibility.

Minimum Benefits Standards

An insurance company must make available to each applicant a policy form offering the basic **core benefits** (Plan A) if it offers any Medicare Supplement policies. An insurance company does not have to issue all or any of the plans B through N. No groups, packages or combinations of Medicare supplement benefits other than plans A through N may be offered for sale in this state.

Plans must be uniform in structure, language, designation, and format to the standard benefit plans A through N.

In Pennsylvania, Medicare supplement policies cannot exclude losses for a pre-existing condition incurred more than **6 months** from the effective date of coverage.

In addition, Medicare supplement policies must include the following provisions:

- Upon exhaustion of all Medicare hospital inpatient coverage, coverage of **90%** of all Medicare Part A eligible expenses for hospitalization (not covered by Medicare) are subject to a lifetime maximum benefit of an additional **365 days**; and
- Coverage of **20%** of the amount of Medicare eligible expenses under Part B, subject to a maximum yearly deductible of $200 of such expenses – with a maximum benefit of at least $5,000 per calendar year.

Insurers offering Medicare supplement policies must simultaneously offer to applicants additional benefit plan standards – providing at least the following coverages:

- The initial Part A deductible;
- Skilled nursing home charges incurred in addition to those covered by Medicare; and
- Coverage of **20%** of eligible expenses incurred under Medicare Part B (in excess of the deductible).

If additional benefit plan coverage is elected by the insured, it will take effect no more than **15 days** following the effective date of his or her Medicare supplement coverage.

Required Disclosure Provisions

Medicare supplement policies must include a renewal or continuation provision that is appropriately captioned and on the first page of the policy. It must include any reservation by the insurance company of the right to change premiums and any automatic renewal premium increases based on the policyholder's age (attained age policies). Issue age policies do not allow an increase in premium based on age; they allow an increase in premiums only because of an increase in benefits.

Insurers must also provide an outline of coverage with each Medicare supplement policy that clearly informs the applicant or insured of the basic nature and provisions of the policy.

Medicare supplement policies must not provide for the payment of benefits based on standards described as *usual and customary*, *reasonable and customary*, or similar words.

Renewal Provisions

Medicare Supplement Insurance policies must be guaranteed renewable.

Duplication of Medicare Benefits Prohibited

A Medicare supplement policy cannot contain benefits that duplicate those provided by Medicare.

Pre-existing Conditions

If a Medicare supplement policy contains any limitations on pre-existing conditions, those limitations must appear as a separate paragraph labeled as *Pre-existing Condition Limitations.* Usually, Medicare supplement policies must cover all pre-existing conditions incurred more than 6 months from

effective date of coverage.

Right to Examine (Free Look)

All Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate stating that the policyholder has the right to return the policy within **30 days** of its delivery for a full refund of premium if not satisfied for any reason.

Guide to Health Insurance for People with Medicare

Issuers of accident and sickness policies that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare by reason of age must provide the applicant a *Guide to Health Insurance for People with Medicare.* The Guide must be provided **at the time of application**. Direct response issuers may deliver the Guide to the applicant upon request, but no later than at the time of policy delivery.

Notice of Benefit Change

The policy must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible and copayment percentage factors.

No more than **30 days** prior to the annual effective date of Medicare benefit changes, issuers must notify policyholders of any of these changes.

Outline of Coverage

The insurance company must present an Outline of Coverage to all applicants **at the time of the application**. Except for direct response policies, the insurance company must obtain a receipt for the Outline of Coverage from the applicant.

Permitted Compensation Arrangements

An insurance company may pay compensation to an agent for the sale of a Medicare Supplement policy. The term *compensation* includes any kind of monetary and nonmonetary remuneration or payment relating to the sale or renewal of the policy, including but not limited to bonuses, gifts, prizes, awards and finder's fees.

The first-year commission may not be more than 200% of the renewal commission for servicing the policy in the second year. The commission provided in renewal years must be the same as the commission in the second year, and must be provided for at least 5 renewal years.

Insurance companies may not pay greater compensation to agents, and agents or producers may not receive compensation greater than the **renewal compensation payable by the replacing insurance company** if a policy is being replaced unless the benefits of the new policy are clearly

and substantially greater than the benefits provided by the policy being replaced.

Guaranteed Issue

The **guaranteed issue** provision stipulates that during the 6-month period after an individual eligible for Medicare coverage by age signs up for Part B, an insurance company issuing this type of plans **cannot**

- Deny or condition the issuance or effectiveness of any Medicare Supplement policy available for sale in this state;
- Discriminate in the pricing of that policy because of the health status, claims experience, receipt of health care or medical condition of an applicant; or
- Impose an exclusion of benefits based on a pre-existing condition under the policy.

This does not prevent the exclusion of benefits during the first 6 months based upon a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

C. Other Options For Individuals With Medicare

1. Employer Group Health Plans

Disabled Employees

The Omnibus Budget Reconciliation Act of 1990 (OBRA) requires that large group health plans (100 employees or more) must provide primary coverage for **disabled individuals** under age 65 who are not retired.

Employees with Kidney Failure

The Omnibus Budget Reconciliation Act of 1990 as amended by the Balanced Budget Act of 1997 requires the employer health plan to provide primary coverage for **30 months** for individuals with end-stage renal (kidney) disease before Medicare becomes primary.

Individuals Age 65 and Older

If an employee is still employed upon reaching age 65, federal laws require allowing the employee to remain on the group health insurance rolls and to defer Medicare coverage until retirement. The employee has the right to reject the company's plan and elect Medicare, but the company can offer no incentives for switching to Medicare.

If an employee remains on the group plan and signs up for Medicare, in groups of fewer than 20 employees, Medicare will be the primary coverage. In groups of 20 or more, the **group coverage will be primary** over Medicare.

Know This! Anyone over the age of 65 may choose to either keep the employer's group health coverage or elect coverage through Medicare.

2. Medicaid

Medicaid is a federal and state funded program for those whose income and resources are insufficient to meet the cost of necessary medical care. Individual states design and administer the Medicaid programs (typically through the state's Department of Public Welfare) under broad guidelines established by the federal government.

Eligibility

To qualify for Medicaid, individuals must meet income and other eligibility requirements. Once a person is determined to qualify with low income and low assets, the person must meet other qualifiers, some of which are blindness, disability, pregnancy, age (over 65), or caring for children receiving welfare benefits. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL).

After the implementation of the Affordable Care Act, new, modernized rules regarding verification of Medicaid eligibility will mean that state Medicaid agencies will rely primarily on information available through data sources (such as the Social Security Administration, the Departments of Homeland Security and Labor) rather than paper documentation from families. Each state has prepared a verification plan for Medicaid in order to comply with the new rules.

In addition to certain levels of income and assets, there are other nonfinancial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Benefits

Medicaid mandates that the states provide at least the following services:

- Physician’s services;
- Inpatient hospital care;
- Outpatient hospital care;
- Skilled nursing home services;
- Laboratory and x-ray services;
- Home health care services;
- Rural health clinic services;
- Periodic screening, diagnosis, and treatment;
- Family planning services; and
- Medicaid also pays for prescription drugs, dental services, private duty nursing services, eyeglasses, check-ups, and medical supplies and equipment.

D. Long-Term Care (LTC) Policies

Long-term care policies, which can be marketed in the form of individual policies, group policies, or as riders to life insurance policies, provide coverage for individuals who are no longer able to live an independent lifestyle and require living assistance at home or in a nursing home facility. Long-term care policies can vary in the number of days of confinement

covered, the number of home health visits covered, the amount paid for nursing home care, and other contract provisions. They also must provide coverage for at least **12 consecutive months** in a setting other than an acute care unit of a hospital.

1. Eligibility for Benefits

Normally to be eligible for benefits from a long-term care policy, the insured must be unable to perform some of the activities of daily living (ADLs). Activities of daily living include *bathing, dressing, toileting, transferring positions* (also called mobility), *continence,* and *eating*.

2. Comprehensive Coverage

Most long-term care policies sold today are **comprehensive policies**. This means they cover all care and services, except for those specifically excluded, in the following settings:

- The insured's home, including
  - Skilled nursing care, occupational, physical, and rehabilitation therapy;
  - Help with personal care, such as bathing and dressing;
  - Homemaker services, such as meal preparations or housekeeping;
- Adult day health care centers;
- Hospice care;
- Respite care;
- Assisted living facilities;
- Alzheimer's special care facilities; and
- Nursing homes.

3. Levels of Care

Generally, long-term care policies will cover 3 levels of care: skilled nursing care, intermediate care, and custodial care. In addition to these levels of care, the long-term care policy may provide coverage for home health care, adult day care, hospice care or respite care, all of which can be received at home.

Skilled Care

Skilled care is daily nursing and rehabilitative care that can only be provided by medical personnel, under the direction of a physician. Skilled care is almost always provided in an institutional setting. Examples of skilled care include changing sterile dressing and physical therapy given in a skilled nursing care facility. **Care that can be given by nonprofessional staff is not considered skilled care.**

Intermediate Care

Intermediate care is occasional nursing or rehabilitative care provided for stable conditions that require daily medical assistance on a less frequent basis than skilled nursing care. It is ordered by a physician, and skilled medical personnel would deliver or monitor this type of care. Intermediate care could be as simple as giving medication to a group in physical therapy once a day or changing a bandage. It may be carried out in a nursing home, an

intermediate-care unit or in the patient's home.

Custodial Care

Custodial care is care for meeting personal needs such as assistance in eating, dressing, or bathing, which can be provided by nonmedical personnel, such as relatives or home health care workers. Custodial care can be provided in an institutional setting or in the patient's home. In other words, it involves caring for a person's activities of daily living, and not hospital or surgical needs.

Know This! Skilled care and intermediate care require the assistance of medically licensed personnel. Custodial care may be administered by nonmedical personnel.

Home Health Care

Home health care is care provided by a skilled nursing or other professional services in one's home. Home health care includes occasional visits to the person's home by registered nurses, licensed practical nurses, licensed vocational nurses, or community-based organizations like hospice. Home health care might include physical therapy, occupational therapy, speech therapy, and medical services by a social worker.

Adult Day Care

Adult day care is care provided for functionally impaired adults on less than a 24-hour basis. It could be provided by a neighborhood recreation center or a community center. Care includes transportation to and from the day care center, and a variety of health, social and related activities. Meals are usually included as a part of the service.

Community Care

Residential Care is provided while the insured resides in a retirement community or a residential care facility for the elderly (RCFE). In some arrangements, the degree of independence is the same as living in one's own home; however, this care provides a physical and social environment that contributes to continued intellectual, psychological and physical growth. These facilities are commonly for the middle and upper classes because of the costs.

Assisted Living offers help with nonmedical aspects of daily activities in an atmosphere of separate, private living units. In addition to providing meals, transportation for medical appointments, activities, and pleasure trips, assisted living may provide:

- Linens and personal laundry service;
- Assistance with dressing and bathing;
- Reminders regarding medication; and
- Assistance with eating.

Continuing Care Retirement Communities (CCRCs) have increased in

popularity during recent years because they allow residents to feel independent in their own home setting but are situated in a community of seniors commonly going through the same aging process.

Homes in these communities may be attached homes, mobile homes, or condominiums built in an exclusive subdivision. The houses are purposely built specifically to accommodate seniors and include features such as wide doors and ramps beside stairs to accommodate wheelchairs. Ease of access is addressed during construction so that residents with walkers and canes can move around safely.

The focus of the community is to provide activities to involve senior residents with social and recreational activities. Congregating is encouraged to promote a person's mental health and avoid becoming complacent.

Suitability depends on the health of the person and the degree of medical treatment required. As a rule, the person should be of general health with assistance limited to a visiting nurse or home health aide. Residents are expected to be involved with their medical doctors and not depend on services within the CCRC. Some communities may offer graduated levels of care on one campus so residents do not have to relocate due to failing health.

Cost will depend on the community with individual accommodations and larger staff being more expensive. Communities with communal accommodations and less staff will be less expensive.

Respite Care

Respite Care is designed to provide relief to the family caregiver, and can include a service such as someone coming to the home while the caregiver takes a nap or goes out for a while. Adult day care centers also provide this type of relief for the caregiver.

4. Benefit Periods

Long-term care policies usually include an **elimination (waiting) period** similar to those found in disability income policies. Long-term care elimination periods may range from 0 to 365 days *(make sure to check your state-specific requirement in the regulations section)*. The longer the waiting period, the lower the premium. Insurers usually give insureds an option to select the elimination period that best suits their needs. LTC policies also define the **benefit period** for how long coverage applies, after the elimination period. The benefit period is usually 2 to 5 years, with a few policies offering lifetime coverage. The longer the benefit period, the higher the premium will be.

5. Benefit Amounts

The benefit amount payable under most LTC policies is usually a specific fixed dollar amount per day, regardless of the actual cost of care. *For example*, if an insured has a fixed daily coverage of $100 and the care facility only charges $90 a day, the insurance company will pay the full amount of

$100 a day. Some policies pay the actual charge incurred per day. Most LTC policies are also **guaranteed renewable**; however, insurers do have the right to increase the premiums.

Know This! LTC policies must be guaranteed renewable.

6. Optional Benefits

For an additional premium, optional benefits are available with long-term care policies.

Guarantee of Insurability

Guarantee of insurability option allows the insured to periodically increase benefit levels without providing evidence of insurability. The amount is usually limited to allowing a 5% compounded annual increase.

Cost of Living and Inflation Protection Rider

All long-term care insurance policies must offer policyholders the option of purchasing coverage that raises benefit levels to account for reasonably anticipated increases in the costs of long-term care services covered by the policy.

The most common forms of **inflation protection** are

- 5% compounded annually;
- 5% simple; and
- Guaranteed purchase option.

With a simple interest increase, the daily benefit is increased by a fixed amount each year. If the increase is based on compound interest, the daily benefit increases by the increasing dollar amount each year. Compounding inflation increases will accelerate the benefit amount more quickly than simple interest inflation increases, but is also more costly.

Insureds can also use life insurance products to help pay for long-term care services. The **cost of living rider** attached to a life insurance policy allows the policyowner purchase increasing term insurance coverage to keep up with expected increases in the cost of living. This rider addresses the inflation factor by automatically increasing the amount of insurance *without evidence of insurability* from the insured. The face value of the policy may be increased by a cost of living factor tied to an inflation index such as the Consumer Price Index (CPI).

7. Exclusions

Long-term care policies may have the following **exclusions**:

- Pre-existing conditions or diseases;
- Mental and nervous disorders or disease (except for organic cognitive disorders such as Alzheimer's disease, senile dementia and Parkinson's disease);
- Alcoholism and drug addiction;

- Treatment or illness caused by war, participation in criminal activities, or attempted suicide; and
- Treatment payable by the government, Medicare, workers compensation or similar coverage.

8. LTC Partnership

LTC partnerships allow those who have exhausted or at least used some of their private LTC benefits to apply for Medicaid coverage without having to meet the same means-testing requirements. The partnership between LTC coverage and Medicaid works by disregarding some or all assets of applicants for Medicaid who have exhausted private LTC benefits and by exempting those assets from estate recovery after the insured's death. The partnership program was created to encourage those who would not otherwise do so to purchase LTC insurance, to reduce the incentives to transfer assets to qualify for Medicaid sooner, and to contain Medicaid spending on LTC services.

9. Pennsylvania Regulations and Required Provisions

Shopper's Guide

A long-term care insurance **Shopper's Guide** must be provided in the format developed by the National Association of Insurance Commissioners (NAIC). The shopper's guide must be presented to the applicant prior to completing the application (in the case of producer solicitation), or in conjunction with the application (in the case of direct response solicitations).

Outline of Coverage

The **outline of coverage** must follow the standard format set out in the insurance regulations including information about the insurance company, the policy number and important features of the policy. The outline of coverage must be a separate document, and must be delivered to the insured prior to the application or enrollment form.

Right to Examine (Free Look)

Individual long-term care insurance policyholders and group certificate holders who contribute to the cost of their long-term care coverage have the right to return the policy within **30 days** of its delivery and have the premium refunded if, after examining the policy or certificate, they are not satisfied for any reason.

Pre-existing Conditions

For long-term care insurance, the term *pre-existing condition* cannot be defined more restrictively than conditions for which the insured has been treated in the last 6 months. If a condition is, in fact, pre-existing, the insurance company will not have to cover that condition for the first 6 months of the contract.

If a long-term care policy replaces another long-term care policy, the new

policy must reduce any pre-existing conditions limitations to the extent that they have been satisfied in the old policy.

If a long-term care policy has limitations for pre-existing conditions, those must be clearly labeled and printed in a separate paragraph.

Continuation and Conversion

Group long-term care issued in this state must provide covered individuals with a basis for continuation or conversion of coverage.

An individual whose coverage under a group policy would otherwise terminate, and who has been continuously insured under the group policy for at least **6 months** prior to termination, will be eligible for conversion of coverage.

The application and the first premium for a converted policy must be remitted no more than **31 days** after the termination of coverage under the group policy.

Unintentional Lapse

In Pennsylvania, the following provisions have been instituted to protect insureds from unintentional lapse of long-term care policies:

- An individual long-term care policy cannot be issued until the insurer has received from the applicant either a written **designation of at least one person**, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium, or a written waiver dated and signed by the applicant reflecting their decision not to designate additional persons. An applicant has the right to designate at least one other person who will receive a notice of their policy's termination. The insured may change this designation at least once every 2 years;
- A long-term care policy **may not lapse** because of unpaid premiums unless the insurer gives at least **30 days' notice**; and
- Long-term care insurance policies should include a provision that provides for **reinstatement of coverage** in the event of lapse. This option is available within 5 months of termination and allows for the collection of unpaid premiums.

Required Disclosure Provisions

All long-term care policies must disclose and explain the renewability provisions. Any riders or endorsements must also be disclosed in the policy. If the terms usual and customary or reasonable and customary are used, the meaning of those terms must be fully disclosed. Any other limitations or conditions of eligibility for long-term care benefits must be fully disclosed. With regard to life insurance policies that provide an accelerated benefit for long-term care, the policy must include a statement to the effect that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor.

Inflation Protection

In Pennsylvania, an inflation protection feature must be no less favorable than one of the following:

- Increases benefit levels annually, so that increases are compounded annually at a rate of at least **5%**;
- Guarantees the individual the right to periodically increase benefit levels without providing evidence of insurability or health status – so long as this option was not declined during the previous period. The amount of this increase cannot be less than the difference between the existing policy benefit, and such a benefit compounded annually at a rate of at least **5%**; or
- Covers a specified percentage of reasonable charges, and does not include a maximum specified indemnity limit.

Nonforfeiture Benefit

Long-term care policies or certificates issued or delivered in this state must offer to the applicant **nonforfeiture (default or lapse) benefits**. These nonforfeiture values, such as reduced paid-up insurance, may apply to the nursing home benefits or to all benefits provided by the policy. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In group long-term care insurance policies, the offer to purchase a policy that includes a nonforfeiture benefit must be made to the group policyholder.

If a policyholder or certificate holder declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that must be available for a specified period of time following a substantial increase in premium rates.

In Pennsylvania, the contingent benefit on lapse will be triggered every time an insurer increases an insured's premium rates to a level that results in an annual premium that exceeds the initial annual premium (based on the insured's age), and the policy subsequently lapses within **120 days** of the increase. Unless otherwise required, policyholders will be notified at least **30 days** prior to this increase.

Benefit Triggers

In Pennsylvania, LTC benefits depend upon the insured's inability to perform activities of daily living (ADLs), and on cognitive impairment. Benefits must begin when the insured is unable to perform **at least 3 ADLs.**

An individual will be considered *chronically ill* if he or she has been certified by a licensed health care practitioner as either unable to perform at least 2 activities of daily living for at least 90 days due to a loss of functional capacity, or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Replacement

If a long-term care insurance policy or certificate replaces another, the replacing insurance company **must waive** any time periods applicable to **pre-existing conditions, waiting periods and probationary periods** in

the new long-term care policy or certificate for similar benefits to the extent that similar exclusions have been satisfied under the original policy or certificate.

During replacement, producers must list any policies that are still in force and any sold in the past **5 years**.

Standards for Marketing

Every insurance company marketing long-term care insurance coverage must establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. Insurance companies must have marketing guidelines to ensure excessive insurance is not sold or issued.

Suitability of Recommended Purchase

When recommending the purchase or replacement of any long-term care policy, an agent must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

Every insurer marketing long-term care insurance coverage must establish marketing procedures to ensure that:

- Any comparison of policies will be fair and accurate;
- Excessive insurance will not be sold; and
- Every reasonable effort is made to identify whether a prospective applicant for long-term care insurance already has accident and health or long-term care insurance, and the types and amounts of any such insurance.

Long-term care insurance policies are also subject to the same marketing requirements regarding twisting, high-pressure tactics, and cold lead advertising as Medicare supplement policies.

Permitted Compensation Arrangements

An insurer may provide commissions or other compensation to an agent or broker for the sale of a long-term care policy only if the first year's commission is not greater than **50%** of the first year's premium.

The commission or other compensation provided for a minimum of **5 subsequent years** cannot exceed **10%** of the renewal premium.

Penalties

In addition to any other penalty, any insurer found to have violated the requirements relating to the regulations of long-term care insurance or the marketing of long-term care insurance will be subject to a civil penalty of up to **3 times the amount of commissions** paid for each policy involved or **$10,000**, whichever is greater.

E. Chapter Recap

This chapter explained health insurance available to senior citizens and special needs individuals: Medicare, Medicare Supplements, Medicaid, and Long-term Care. 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,

For individuals eligible for Medicare coverage who

Secondary Payor 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

Employer Group Health Plans

- Disabled employees: coverage for disabled individuals under age 65
- Employees with kidney failure: primary coverage for 30 months for end-stage rental disease, prior to Medicare
- Individual age 65 or older:
  - Requires employer to continue offering coverage if Medicare is deferred
  - Employer cannot offer incentives for switching plan
  - Medicare is primary if employer has no more than 20 employees

Medicaid

- Medical care for those whose income and resources are insufficient
- Federal and state funded

LONG-TERM CARE

Policies

- Available as individual policies, group policies, or as riders to life insurance policies
- Coverage for individuals who require living assistance at home or in a nursing home facility
- Must provide at least 12 months of consecutive coverage in a setting other than an acute care unit of a hospital
- Guaranteed renewable, but insurers may increase premiums

Levels of Care

- *Skilled care* - daily nursing and rehabilitative care provided by medical personnel
- *Intermediate care* - occasional nursing or rehabilitative care provided for stable conditions that require daily medical assistance on a less frequent basis than skilled nursing care
- *Custodial care* - care for a person's activities of daily living provided in an institutional setting or in the patient's home
- *Home health care* - provided by registered nurses, licensed practical nurses, licensed vocational nurses, or community-based organizations like hospice in one's home
- *Residential Care* - provided while the insured resides in a retirement community

- *Adult day care* - provides for functionally impaired adults on less than a 24-hour basis
- *Respite Care* - provides relief to the family caregiver; adult day care centers may also provide this type of relief
- *Assisted living* - provides help with nonmedical daily activities

Coverage and Benefits

- 12 consecutive months
- Elimination period of 30 days or more
- Benefit period of 2-5 years; some offering lifetime coverage
- Longer benefit periods result in higher premium
- Trigger: inability to perform ADLs (usually 2 - 3)

Required Provisions

- Must be guaranteed renewable
- Must offer inflation protection
- Free look period - 30 days
- Pre-existing conditions exclusion - no more than 6 months
- Must cover Alzheimer's disease
- Disclosure requirements - outline of coverage and policy summary