

Chapter Ten



THE COSTS OF CARE

A worker's income is usually cut in half upon retirement while medical expenses are likely to increase. Medicare premiums continue to rise at about three times the inflation rate. The average annual medical bill for persons over age 65 now exceeds \$3,000. Currently, only about 80% of the costs of health care for older adults is met by Medicare insurance. Therefore, it is imperative that all seniors become aware of factors affecting medical costs and ways to reduce their health care expenses.

SHORTER HOSPITAL STAYS: THE "DRG"



Over the past 15 years, the length of time required for a hospital stay has been dramatically reduced. This is primarily due to advances in medical technology. In addition, a U.S. Health and Human Services regulation now limits Medicare reimbursement to a "prospective payment amount" for each of 468 Diagnostic Related Groups (DRG's) diagnosed in advance by the physician. This means that the

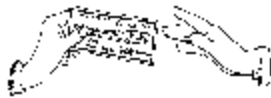
Medicare payment amount is determined in advance for each geographical region of the nation by the DRG for the particular medical treatment or procedure. The purpose of the regulation is to provide an incentive to discharge patients from hospitals as soon as medically feasible in order to reduce health care costs. Occasionally, medical staff feel pressure to discharge a patient who needs to remain in the hospital for a longer period because the chargeable amount under the Medicare DRG is exceeded. You should know that the DRG regulations were not intended to force early discharge harmful to the patient in an individual case. You may have to insist on a frank talk with your doctor if you believe you (or someone you are concerned about) are being discharged before you are ready to leave the hospital.

You have the right to appeal if you believe that you are being asked to leave the hospital prematurely. In 1999, the Department of Health and Human Services passed new regulations regarding patients' rights in hospitals. All hospitals must follow these regulations in order to participate in Medicare and other federally funded programs. These regulations require hospitals to inform each patient or their representative of the patient's rights in advance of discontinuing the patient's care. Moreover, hospitals must establish a "formal grievance process for prompt resolution of patient grievances," whether those grievances are written or oral. "The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the . . . Peer Review Organization (PRO)." The PRO consists of groups of practicing doctors and other health care professionals paid by the federal government to monitor and improve the care given to Medicare patients. Details of the review under Medicare's Prospective Payment System are described in a pamphlet,

"Knowing Your Rights," published by AARP. Write to AARP Fulfillment, 601 E Street, N.W., Washington, DC 20049.

In Kentucky, the designated PRO is Health Care Excel, Inc. Their toll free number is: 1-800-288-1499. The PRO will answer questions relating to an appeal from a hospital discharge and other Medicare decisions. Also see the handbook, Medicare and You 2000" (HCFA, 2000, or current ed.).

ASSIGNMENT OF MEDICARE REIMBURSEMENT



A large number of physicians and health care suppliers will accept an assignment of Medicare coverage from the patient in full payment for services rendered. "Accepting assignment" refers to the agreement of the physician to: (1) accept Medicare's determination as to the amount which is a reasonable fee for the service rendered; and to (2) receive payment directly from Medicare for 80% of the bill so that the patient pays the physician directly for the 20% co-payment. Because the law does not require physicians to accept assignment in most cases, seniors may be required to pay the doctor directly for his or her services and wait for Medicare to reimburse them. The only avenue of relief from this situation for seniors is to become familiar with publications about the quality of insurance coverage. Federal law requires each Medicare insurance carrier to publish a directory of physicians and suppliers who agree to accept assignment each year. Social Security Offices and your local senior citizen center should have copies of these directories after October of each year. You may also telephone 1-800-213-5452 to learn whether your doctor, clinic or hospital will accept an assignment of Medicare claims.

Even if your physician will not accept assignment of the approved Medicare amount as payment in full, he or she is required to file the patient's claim for reimbursement with Medicare. Moreover, for all Medicare patients the physician's charges in 2000 may not exceed 115% of the approved Medicare amount for the service rendered. For example, if the Medicare approved fee for the doctor's service is \$100, a participating physician charges only \$100. Medicare pays \$80 of the fee and you pay \$20. Conversely, a non-participating physician's charge would be limited to 115% of \$95 (Medicare subtracts 5% from the fee for setting the approved amounts). Non-participating physicians are also required, prior to elective surgery, to give the patient a written estimate of the cost of the surgery if the cost is expected to exceed \$500.

Some health care professionals maintain a hotline for consumers which answers health related questions. For example you may call the following:

1. "Ask a Nurse," 1-800-535-1111 (this service is free);
2. "Ask the Pharmacist," 1-900-420-0275 (\$1.95 a minute); and,
3. "Doctors by Phone," 1-900-77-DOCTOR (\$3 a minute).

While "Ask a Nurse" is by far the most popular help-line, all of these help-lines are useful in some cases. Nevertheless, there is no substitution for an office visit to your doctor.

MEDICAL INSURANCE

With rising health care costs, it is vital that you investigate the medical insurance you now have or plan to purchase. First, there are many types of policies and many

companies offering insurance protection against loss of assets to meet high health care expenses.

The *specific sum indemnity* policy is limited to benefits which pay a specific dollar amount. This amount varies for different types of illnesses or hospitalizations. The *service* policy usually pays a percentage of the total medical costs which are incurred. Other policies cover only costs associated with certain diseases such as cancer. In general, policies for specific illnesses are likely to be a poor bargain for the premium. Major medical insurance or catastrophic illness insurance offers, for a relatively low premium, protection against large medical expenses. Depending on your individual needs, insurance against major illness may be the only protection required in addition to Medicare.

Many employers, unions, and associations such as the American Association of Retired Persons (AARP), offer group insurance which is usually less expensive than individual insurance. After retirement, an employee ordinarily has the option to continue the same protection previously provided by the employer, for a premium. Sometimes employee benefits may continue coverage for family members after the employee's death. Many companies sell hospitalization and other medical benefits both to groups and to individuals.

Increasingly, Health Maintenance Organizations (HMO's) offer a broad range of services, including preventive medicine, at a set monthly premium. A small but increasing number of older persons are members of HMO's.

A Preferred Provider Organization (PPO) is a group purchasing plan, usually sponsored by a combination of hospitals and physicians and sold to employer groups. This type of plan offers greater coverage to an employee or insured who chooses to use the provider's hospital facilities

and who obtains a second opinion before surgery. However, these plans must preserve the patient's right to choose his own physician.

MEDIGAP INSURANCE

Among the types of medical expenses not generally covered by Medicare, or other supplementary insurance policies, are routine physical check-ups, eye examinations and glasses, dental care, cosmetic surgery, homemaker services, health care costs while traveling or living abroad, and intermediate and custodial care. As previously discussed in Chapter 3, the annual Medicare costs paid for by the patient continues to increase each year. Thus, the deductible and 20% co-payment (which you must make) as well as the limit on the customary charge for "medically necessary" procedures results in substantial gaps in coverage.

To help fill these gaps, private insurance companies developed supplemental health policies, often referred to as Medigap Insurance. In 1992, these plans were standardized. Indeed, all new policies issued in 1992 and afterwards must contain certain "core" benefits which pay for most charges not covered by Medicare. Medigap covered costs include the co-insurance payments for both Parts A and B, the price of three pints of blood, and 365 paid hospital days. However, the most basic plan does NOT pay the deductible cost of either Part A or B. You can choose this basic plan or any of its nine variations.

The current law does not require that existing policies be updated so you should carefully evaluate your needs before getting a new policy. To help you decide which Medigap policy is right for you, the Kentucky Department of Insurance will send you a free booklet entitled "Guide to

Health Insurance for People with Medicare.” This booklet is updated each year. It contains vital information about insurance coverage for Medicare beneficiaries in easy to understand language. Call or write the Kentucky Department of Insurance, P. O. Box 517, Frankfort, KY, 40502, (502) 564-3630 or 1-800-959-6053.

Insurance agents are not permitted to sell policies that substantially duplicate your present coverage unless you sign a statement indicating you will cancel your present policy after the new policy becomes effective. An agent who sells comparable coverage violates federal law and may be subject to harsh criminal and/or civil penalties. You should report such an agent to the Kentucky Department of Insurance at 1-800-959-6053 or call the federal Medicare hotline’s toll-free number at 1-800-638-6833.

Some pointers in buying health insurance are:

1. Define and carefully consider your individual needs.
2. Be skeptical of salesmen (especially door-to-door or telephone), and advertisements from out-of-state companies which may not be authorized to do business in Kentucky.
3. Check the policies of several companies before you purchase. Compare benefits, exclusions, coverage limitations, and premiums. Question the agent carefully.
4. Check the company’s solvency rating with Moody’s Investors Service. Moody’s researches and rates various insurance companies. You can call Moody’s at 1-800-811-6980 or visit www.moody.com for more information. Your most important consideration is the company’s financial soundness.
5. Check for a clearly worded outline of coverage and read the outline carefully.

6. Read the entire policy carefully, and ask others for help in interpretation. The insurance company writes the contract, often in confusing language. Ideally, ask your attorney for assistance.
7. Watch for exclusions for pre-existing illnesses or other physical conditions. Be sure to understand how these exclusions are defined and how they can deny you coverage.
8. Check your right to renew your policy and when premiums can be increased. Check when the company can cancel and under what circumstances.
9. Check transferability of coverage should you move to another state.
10. If possible, ask other people insured by the company about their claims experiences.
11. Determine the length of the waiting period before the coverage becomes effective.
12. Do not buy the insurance if medical coverage is limited to accidents. A good policy will cover both illnesses and accidents.
13. By law, you are entitled to a thirty day "free look" during which you can cancel the policy and get a refund of previously paid premiums.
14. Try to avoid duplication of coverage. Remember, when buying Medigap insurance, it is illegal for an agent to sell you similar coverage unless you plan to drop your current policy.
15. Do not over insure -- your situation may not require 100% coverage.
16. Complete the application carefully. Include any required medical history regardless of what the agent says. If this information is omitted, the company can escape liability. Keep a copy for your records!

17. Never pay in cash. Pay by check, money order or bank draft made payable to the insurance company and no one else.
18. If you do not receive your policy within 30 days, write the insurance company and ask the reason for delay. If more than 60 days pass without a response, contact the Kentucky Department of Insurance.
19. If you have a question or complaint write or call: Commissioner of Insurance, Legal and Enforcement Division, Frankfort, KY 40601, (502) 564-3630 or 1-800-595-6053.

Filing insurance claims is difficult, complex, and sometimes traumatic. For example, hospital social workers often help patients file claims. Moreover, the hospital's business office can explain complicated bills and symbols. Do not be afraid to ask for an explanation of your bill. Examine the bill to make sure you received the services for which you are being charged. A 1986 Kentucky law requires hospitals to provide an itemized statement of services to patients. Finally, many senior citizen centers provide help for insurance questions, and your insurance agent is another resource. You may also seek advice from your attorney.

NURSING HOME INSURANCE

Many people believe that Medicare offers full protection against the cost of long-term care in a nursing home. This is simply not true. Medicare pays part of the daily room cost following discharge from a hospital, but only in a skilled nursing facility and only for a limited number of days. In fact, most of the services required after a hospital stay do not require skilled nursing care but can be met by intermediate or custodial care. Since Medicare will not cover such costs, most Medicare supplements or Medigap policies

will not pay for such coverage either. Consequently, you may need to review your own insurance protection as well as the terms of any policy you are thinking of purchasing.

In 1992, Kentucky adopted a model act to promote availability and increase reliability of long term care insurance policies. This act prohibits widespread deceptive practices. There are also policy terms, known as “gateways,” which exclude many kinds of care the insured person may believe are covered. Some examples are a restrictive definition of Alzheimer’s disease and a limitation which provides only skilled nursing care.

You should first ask whether you need long term care insurance. The answer depends on many factors such as your age, health, finances, your overall retirement plan and available family and community help. Two groups who do not need this type of insurance are: 1) persons or families at or near the eligibility ceilings for Medicaid; and, 2) those who have sufficient savings and/or pension benefits to meet any foreseeable nursing home costs.

When purchasing long term care insurance, you must make three important decisions. First, what is the daily benefit under the policy. In other words, how much money will you receive on a daily basis for your care. Find out the current cost of care in your area to help you make this decision. Second, what is the benefit period under the policy. The benefit period is the length of time you will receive payments from the insurance company once you need care. Most policies offer a specific number of years up to and including a lifetime plan. Finally, what is the elimination period. The elimination period is the number of days that must elapse before the insurance begins to pay for your care.

Be sure to read the policy carefully. Remember, the agent wants to make a sale. He must give you an outline of

coverage at the initial solicitation. You need an opportunity to compare this with other policies. Your attorney is experienced in reading contracts and it may well be advisable to consult him or her.

Many agents want you to sign and pay the premium before delivering the policy. You are protected by the thirty day "free look" provision, during which you can reject the policy without penalty. When making the decision to purchase, remember that the odds favor the insurance company which must make a profit. To buy adequate protection, expect to pay a substantial premium even if you buy a policy well before you expect to need its coverage.

Many companies market reliable policies. The Kentucky Insurance Commissioner offers a "Consumer's Guide to Long Term Care Insurance in Kentucky," which is updated annually. This booklet suggests questions to ask the agent and contains a useful chart for comparing policies. To get your free copy, write: Kentucky Department of Insurance, Box 517, Frankfort, KY 40601, (502) 564-3630 or 1-800-595-6053. For more information, you can also write or call the Kentucky Association for Older Persons, 411 E. Muhammad Ali Blvd., Louisville, KY 40202, (502) 587-8673.