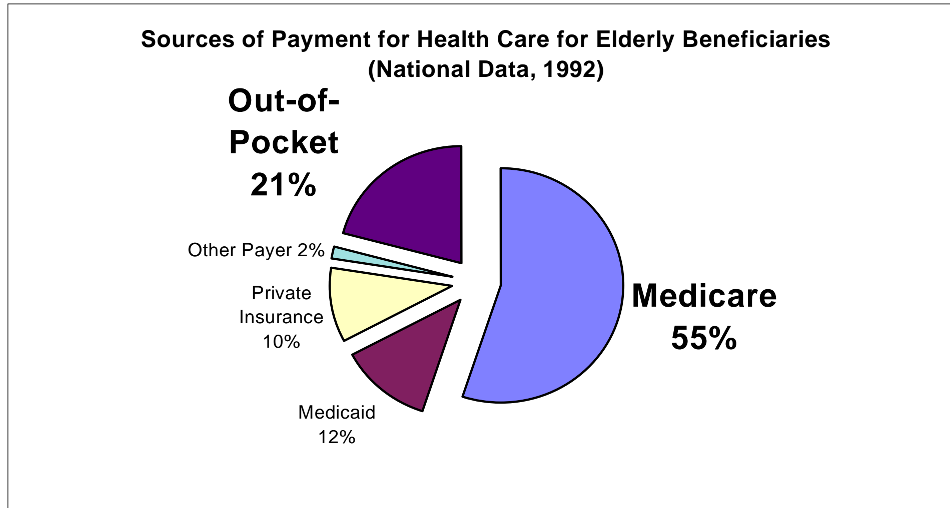
II. HEALTH CARE FINANCING Task Force

Summary

Health care for seniors is financed through a fragmented, confusing patchwork that contributes to the fragmented system in which services are provided.

Seniors rely on Medicare to pay for many of their health care expenses. However Medicare does <u>not cover</u> many services. In fact, **Medicare typically finances only about 55%** of the medical bills for Medicare beneficiaries.[1]



Many seniors do not take full advantage of subsidy programs to help them pay for needed medical care. A conservative estimate is that more than **2,285** seniors in Tompkins County are eligible, but not enrolled, in subsidy programs.

This report contains the following:

I. **Status of Tompkins County Seniors** on Medicare, Medicaid, QMB, SLMB, employer plans, Veterans, other

II. **Issues, Needs & Highlights**

A. Medicare does not cover many needed services
B. Many Tompkins County seniors are eligible but not enrolled in subsidy programs
C. Fragmented financing of fragmented services
D. Threats to Medicare program on the National level
E. Outpatient prescriptions are not covered by Medicare
F. Long Term Care relies mostly on private resources
G. Financial barriers to health care
H. Help in sorting through the options

III. **Action Recommendations**

IV. **Appendices**

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[1] 53 - 55% of 1992 expenses, *Medicare and Health Chartbook*, February 27, 1997, for Committee on Ways and Means, U.S. House of Representatives on the www.access.gpo.gov/congress

HEALTH CARE FINANCING Task Force

I. Status of Tompkins County Seniors

Seniors rely on Medicare to pay for many of their health care expenses. Without this major government support, many seniors would not be able to seek the care that they need; others would become impoverished by the high cost of their care.

However, a little-known fact is that **Medicare typically finances only about 55%** of the medical bills for Medicare beneficiaries.[2]

In 1994, elderly persons **not in nursing homes** spent on average $2,519.00 on health care (or 21% of their average household income). [3] The percentage of their income that seniors pay for health care has actually increased from 11 % to 18 % since the beginning of Medicare.

Why is this? Because Medicare:

- Does not even cover many services. For example:
  Outpatient prescription drugs, Routine physical examinations,
  Non-surgical dental services, Hearing aids and eyeglasses,
  Most long-term care in nursing facilities, the community, or home

- Requires payment of a premium. (Part B [physicians] is $525.60/year),

- Has cost sharing in the form of deductibles and co-pays for most services. For example the patient needs to pay the first $764 of hospitalization costs and the first $100 of physician services.

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[2] 53 - 55% of 1992 expenses, *Medicare and Health Chartbook*, February 27, 1997, for Committee on Ways and Means, U.S. House of Representatives on the www.access.gpo.gov/congress

[3] Electronic Policy Network http://epn.org/library/agmedi/html

So how do seniors cover the other 45% of costs? Nationally in 1994 the most common sources of **supplemental coverage** for senior were:[4]

Type of Supplemental Coverage	Percentage of Medicare Beneficiaries
Medigap	37%
Other separately purchased private insurance	5%
Employer retiree coverage	33%
Medicaid	12%
Other sources	2%
Total beneficiaries with supplemental coverage	89%

This still leaves 11% of seniors with NO supplemental coverage for medical expenses.

Tompkins County Seniors

There is no source of complete information about all the health insurance that seniors in Tompkins County have. This report includes actual numbers for some programs and estimated amounts for others. Together they are the best picture that we have at this time.

A. Covered by Medicare[5] – 8,898

8,898 Aged on Part A (Hospital Insurance)

8,582 Aged on Part B (Supplemental Medicare Insurance)

This shows that some people have Part A but not Part B; this could be due to their not being able to afford the Part B premiums, or to other causes.

[4] Electronic Policy Network http://epn.org/library/agmedi/html

B. Covered by Medicaid and other programs for lower-income people

Many programs are available to help lower-income seniors pay for medical expenses that are not covered by Medicare. The primary program is Medicaid. In Tompkins County, Medicaid now covers 798 people ages 65+ and 142 people ages 60 – 64. This includes approximately 300 people in nursing homes.

The eligibility standard for a non-disabled person 60 – 64 is approximately $354 in income per month; for a person age 65+ it is much higher, at $612 per month. So while seniors ages 60 – 64 do not yet qualify for Medicare, Medicaid might also not be an option for them.

Other subsidy programs are the QMB, SLMB, Q1 and Q2. These programs have increasingly higher income levels to be eligible, and also have increasingly lower levels of subsidy. In Tompkins County the current enrollment in these programs is:

- QMB 418 people Qualified Medicare Beneficiary
- SLMB 38 people Specified Low-Income Medicare Beneficiary
- QI 1 6 people Qualifying Individual 1
- QI 2 4 people Qualifying Individual 2

[5] Medicare enrollment as of July 1, 1997; Medicare Data book, US Government

Income Eligibility Requirements for Subsidized Health Insurance Programs

PROGRAM	*ANNUAL INCOME*
Medicaid	$ 7,344
EPIC	$ 7105-$18,500
QMB	$ 7,105-$ 8,484
SLMB	$ 8,485-$10,116
QI 1	$10,117-$11,352
QI 2	$11,353-$14,664

Benefits

QMB – Pays Medicare Part A ($309 premium per month in 1999 for those few individuals who do not qualify for free coverage) and Part B premiums, deductibles, co-insurance and co-payments for all services covered by Medicare if furnished by Medicaid providers.

SLMB – Pays Medicare Part B premium only.

QI 1 and QI 2 – Pays part or all of Medicare Part B premium; limited funds.

C. Covered by Veterans Administration[6] – 2,750 people (estimated)

Tompkins County, FY 1998

Veteran Population, all ages	6,456
WWII veterans	1,750
Korean veterans	1,000
Vietnam veterans (in their 50's)	1,700
Post-Vietnam veterans	820
Persian Gulf veterans	370
Other peacetime veterans	800

We've estimated that veterans of WWII and Korea are likely to be seniors. Services are provided at VA locations on a sliding-fee scale. The amount of the co-pays depends on income and assets and if medical need is 10% or more service-related. The VA does pay for medication and has a large mail-out program.

D. Retiree Coverage from Major Employers – Tompkins County

Note that some seniors are still active employees and may have coverage in this way.

The top ten employers in Tompkins County are Cornell University, Ithaca College, Borg Warner, school districts (covered by a BOCES plan), Tompkins County government, Cayuga Medical Center, Wegmans, Emerson Power Transmission, NYSEG and Axiohm. These top ten groups employ about 16,800 workers, or 36% of the current workforce. *Most of them offer some type of health insurance coverage to their retirees.* Often their plan will function like a Medigap plan which includes prescription coverage. Many other smaller companies also offer health insurance plans to retirees. <u>However,</u> over the last ten years many companies in Tompkins County are gradually reducing their coverage for retirees. Sometimes this is done by requiring co-pays and premiums resulting in more cost sharing and some employees' dropping out of the plan. At other times participation in a managed care plan is required or the employer drops coverage altogether.

On a national level "Less than 30 percent of Medicare beneficiaries today get coverage through their former employers. This type of coverage has been eroding in recent years. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped 20 percent." (President Clinton's report)

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[6] www.va.gov/data.htm, www.va.gov and Syracuse Regional VA, Joe Ortolona (315) 477-4595)

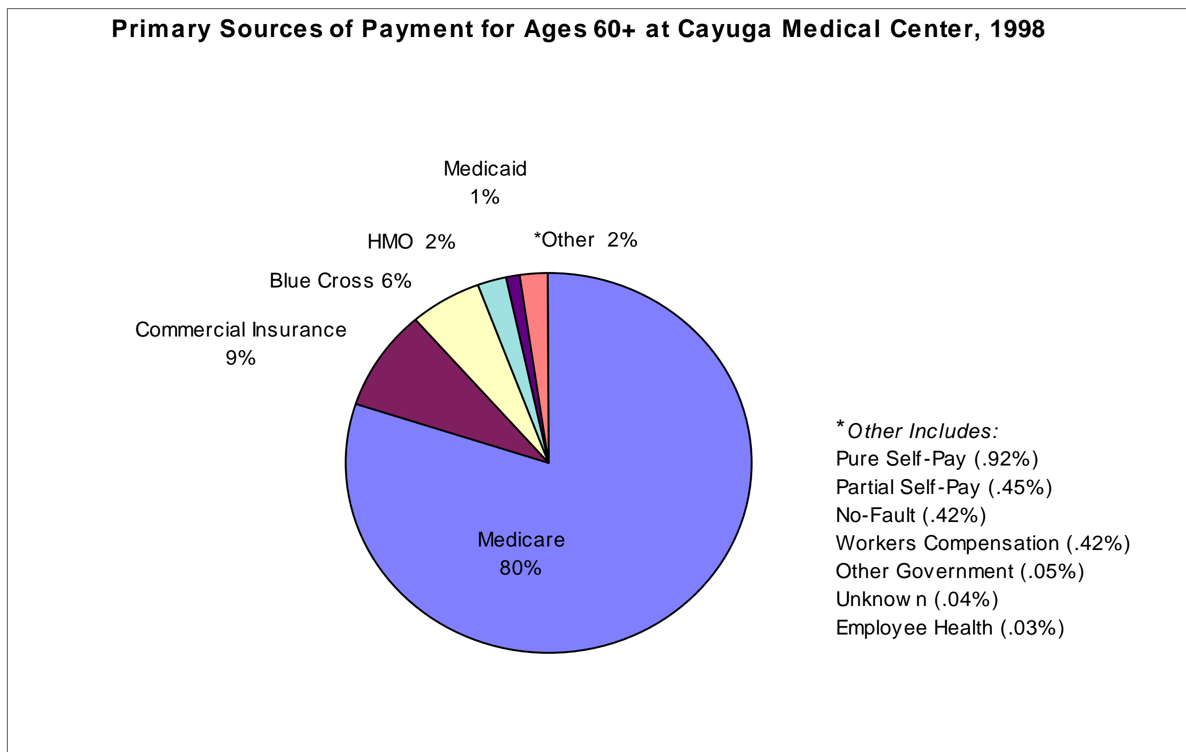
E. Other sources to estimate supplemental coverage

While we do not know exactly how many seniors have supplemental coverage, two other sources provide useful comparisons:

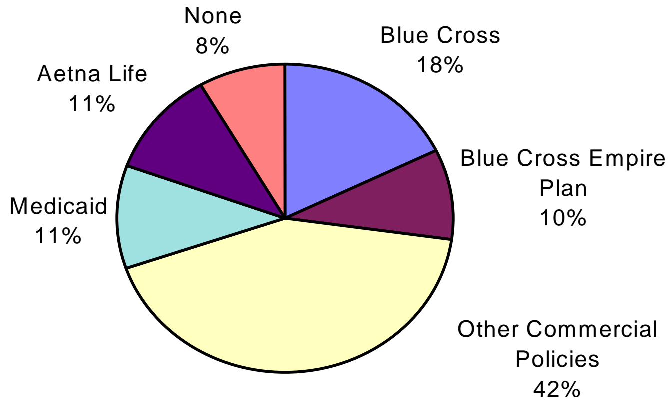
- Secondary Coverage of Seniors receiving care at Cayuga Medical Center
- National figures

<u>Secondary coverage of seniors receiving care at Cayuga Medical Center</u>

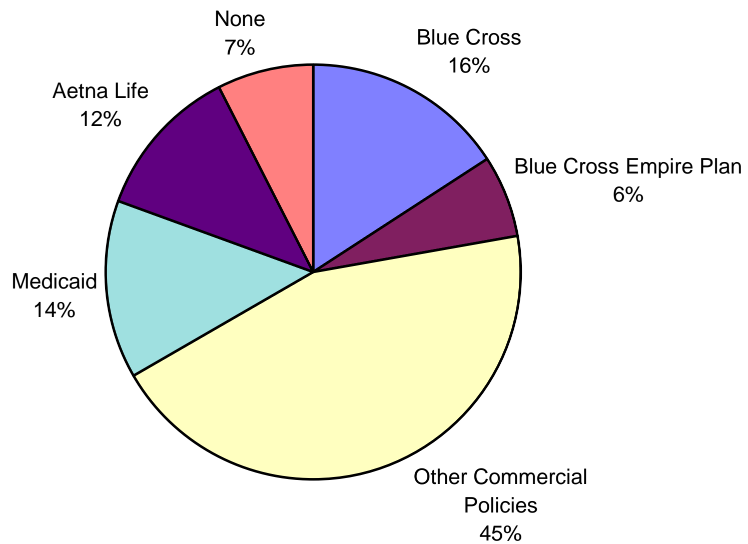
Many seniors in the County receive their care at Cayuga Medical Center, in both outpatient and inpatient settings. Looking at the secondary source of coverage for patients ages 60 and over gives some local data. Note that these figures include seniors from all places of residence; information separating out just Tompkins County seniors was not readily available. The following charts provide information about both the primary and secondary sources of payment for ages 60+:



Secondary Insurance for Inpatients Age 60+ at Cayuga Medical Center, 1998



Secondary Insurance for Outpatients Age 60+ at Cayuga Medical Center, 1998



National Comparisons

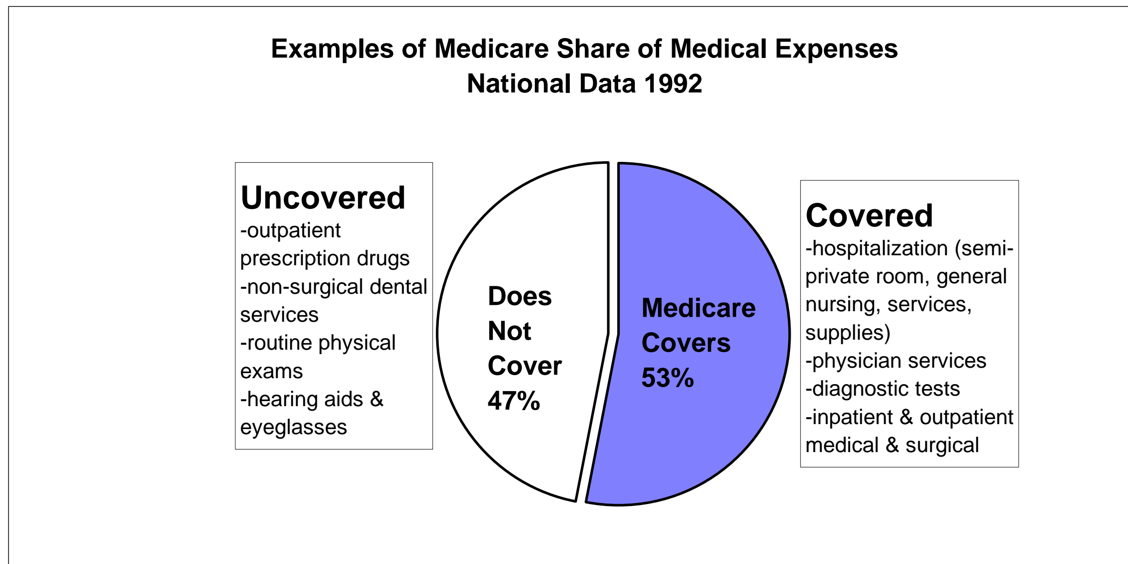
The following table uses national percentages to extrapolate what the Tompkins County numbers would be if its experience were similar to the national (using the 8,898 seniors on Medicare as the total). The last column indicates what little we know, or can estimate, about other coverage.

Type of Supplemental Coverage	**National Percentage Distribution of Medicare Beneficiaries**	**Extrapolated Tompkins County Numbers**	**Actual or Estimated Tompkins County Numbers**
Medigap	37%	3,292	
Other separately purchased private insurance	5%	445	
Employer retiree coverage	33%	2,936	Much higher than 3,000
Medicaid	12%	1,068	798 who are 65+, (142 ages 60 – 64)
Other sources	2%	178	2,750 Veterans, etc.
Total beneficiaries with supplemental coverage	89%	7,919	
No supplemental coverage	11%	979	

II. Issues, Needs & Highlights

A. Medicare does not cover many needed services

In 1995 the Federal government spent $4818 per Medicare enrollee. Even so, this does not cover many services. The chart below includes some examples.



In recent years Medicare has expanded the amount of screening programs that it will fund: yearly mammograms, pap smears, pelvic and breast examinations, diabetes glucose monitoring, diabetes education, colorectal cancer screening, bone mass measurement, flu & pneumonia shots.

Appendix A contains information on Medicare coverage and costs.
Also check the Medicare hotline 1-800-638-6833 or www.medicare.gov.

Some major gaps in Medicare coverage are in the areas of prescription medications, dental care, long-term care, help with managing chronic conditions, drug and alcohol problems and social work services. (Information about

financing for mental health services is contained in the mental health task force section of the Millennium report.)

Medigap policies

Some people purchase Medigap policies to cover what Medicare does not. The ten different kinds of Medigap policies cover various costs ranging from co-insurance and deductibles for Parts A and B to prescriptions, preventive screening, and emergency care outside of US. Premiums could cost from $840 up to $2700.00 per year

Appendix B contains information about coverage and costs of Medigap policies

Some of the issues in Medicare coverage are detailed below:

Dental care

Some seniors can not even afford to replace dentures that do not fit properly. Also, there's an exception in the Medicare statute that allows coverage for serious dental operations done in hospitals as inpatient services. However, most such operations are now done on an outpatient basis. Since the law has not caught up with this change, patients can end up owing large amounts of money for their operations or may not have the operations, if neither Medicaid nor private pay is an option.

High cost of ambulance services

Medicare currently does not require that ambulance providers accept assignment for Medicare; thus companies may charge patients for the portion of the fee that Medicare does not cover. This can amount to a lot. For example, the fee for a basic ambulance transfer with one provider is $245 plus $6 per mile. Of this amount Medicare would reimburse $140.58 plus $3.25 per mile. The patients would be responsible for the difference unless they had secondary insurance that

might cover a portion of this. Obviously where there are longer distances, such as in the rural areas of Tompkins County, the total charge would quickly add up.

Medicare regulations are expected to change by the first of 2000 to require that ambulance companies accept Medicare assignment; the patient will still be responsible for the 20% co-pay.

Confusion about coverage

When a policy says that it covers certain services people often do not realize that this may only be if the individual in that specific situation meets particular eligibility requirements.

B. Many Tompkins County seniors are eligible for but not enrolled in supplemental programs.

This can be for many reasons. Some people just do not want to be involved with Department of Social Services. Some people are deterred by the requirement that Medicaid will place a lien on their estate. Some feel it is an invasion of their privacy to provide all the necessary financial information. Some may not be aware that they would qualify. Many older people may be eligible with a spend-down, but do not understand how the system works. Some associate Medicaid with giving up all their assets and have yet to realize that they may have to spend those assets anyway.

Eligibility for Medicaid is based upon many factors including a person's income and assets. The income distribution of seniors is available through the Census; there are no available details about seniors' assets.

For planning purposes, the COFA Millennium Health Care Financing Task Force estimated the number of seniors who would be eligible for various programs if eligibility were based on income alone. The actual number would obviously be lower because of a senior's assets.

The following chart provides actual enrollment figures and the estimates of those potentially eligible.

Potentially Eligible – 60 years and older				
	Current enrollment	Potentially eligible based only on income	Number of eligibles not enrolled	**If even half of the potentially eligible met the asset criteria**
Medicaid	940	2,809	1,869	**935**
QMB	418	687	269	**135**
SLMB	38	813	775	**388**
Q1	6	450	444	**222**
Q2	4	1,214	1,210	**605**
Total	**1,406**			**2,285**

Tompkins County is not alone is being under-enrolled in the Medicare subsidy program. Families USA last year estimated that half – about 4.5 million elderly and disabled persons – who are eligible for the premium assistance do not know about the program.[7]

EPIC, (Elderly Pharmaceutical Insurance Program epic@health.state.ny.us), is another subsidy program which is under-enrolled in New York State, (564 enrolled with an estimated 3,534 eligible). Section F about prescription costs has more details.

[7] Older Americans Report, June 18, 1999, Vol. 23 No. 24, page 203.

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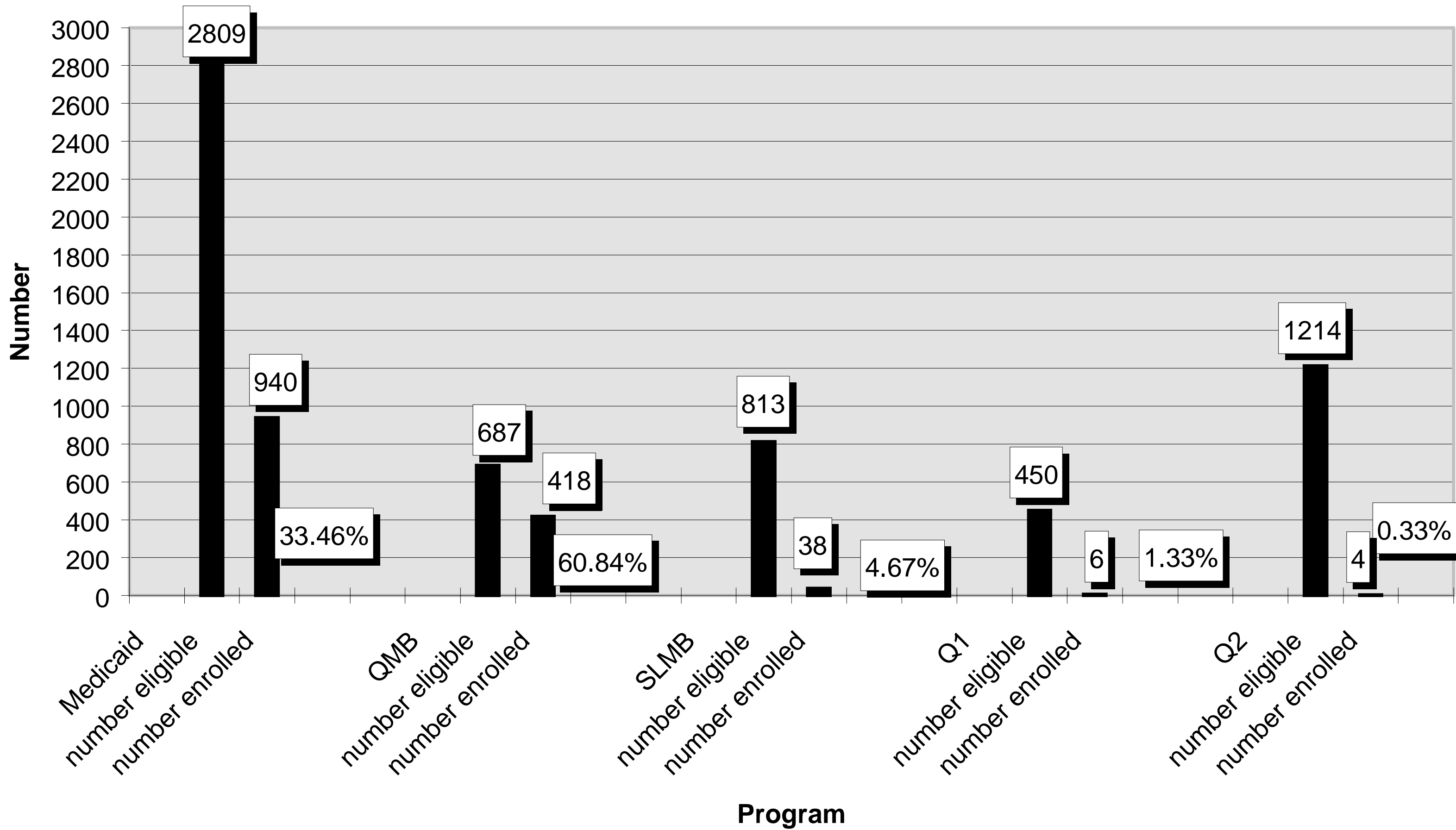

Number of potentially eligible people estimated based on number of Tompkins County seniors within the income guidelines according to 1990 Census.

C. Fragmented financing of fragmented services

Services are too often fragmented. There is an artificial distinction between acute and long term care and between rehabilitative and custodial care. In reality these services often overlap and the need for them changes gradually. There could be more effective care planning if the system were designed for this.

Patients receive EOB's (Explanation of Benefits) from many different providers and it is difficult for individuals to apply the different program rules.

Out of state coverage is often even harder to figure out. The portability of benefits is very confusing. For example, even within New York State if someone moves from Tompkins to Tioga County they need to be re-certified for Medicaid.

President Clinton's recent plan to revise the Medicare program includes proposals for better coordination and case/disease management:

"Since a small fraction of beneficiaries (5 percent) accounts for 45 percent of Medicare spending, targeting their entire range of services or disease-specific services can improve quality as well as reduce costs. … A study of Medicaid in Kentucky and Maryland found that primary care case managers (PCCMs) can reduce use of ancillary services and increase use of preventive services and primary care. …Private sector disease management vendors indicate they are achieving savings of 20 to 50 percent for selected high-cost, chronic diseases, and have begun to guarantee improvement in patient satisfaction and clinical outcomes as well as cost savings.

"Talking about the Medicare-Medicaid dual eligibles: These dual eligibles represent 17 percent of the Medicare beneficiary population and account for 28 percent of total Medicare expenditures. On average, dual eligibles are sicker, older and poorer than other Medicare beneficiaries. … However, these services

are provided by two separate public insurance programs. This complex arrangement of services can be difficult to understand and navigate. In addition, providers for one program may be unaware of the actions of providers for another program, unintentionally duplicating or contradicting each other. This is exacerbated by the incentives to cost-shift between payers."[8]

D. Threats to Medicare Program – National level

Total Medicare spending has increased at a rate that is much higher than general inflation. Expenditures per enrollee were $583 in 1975 but $4818 in 1995 (adjusted to comparable dollar value). Total expenditures are projected to rise from $174.2 billion in 1995 to $449.3 billion in 2005.[9]

Concern about these expenditures has generated many different proposals to contain costs. The **Balanced Budget Act of 1997** included many cost-cutting features such as reducing reimbursement to providers and restricting the amount of home care services. For example, since January 1998, Medicare pays home care agencies on the Interim Payment System (IPS). IPS is calculated through a complicated Health Care Finance Administration (HCFA) formula based on past costs. The agency receives a fixed amount of revenue for each unduplicated Medicare patient served in a calendar year. They receive the same amount per patient regardless of how many visits are provided, how many services are provided or how many times the patient comes in and out of service in a given year.

This has resulted in reductions in service both locally and nationally. A Home Health Access Study conducted by the American Association of Homes and Services for the Aging found that "26 percent of the agencies surveyed restrict admission for some Medicare beneficiaries; 56 percent have decreased the

[8] President Clinton's plan for "Strengthening and Modernizing Medicare for the 21st Century," July, 1999.
[9] Electronic Policy Network http://epn.org/library/agmedi/html

total number of Medicare beneficiaries they serve; and 71 percent have decreased their total number of visits per patient." [10]

The **Breaux-Thomas proposal** includes premium support (similar to a voucher) rather than support for defined services. The amount of the voucher would be set to cover 75% of what they figure will be your "average" medical costs; the patient would be responsible for the other 25%, plus any out-of-pocket costs like deductibles and/or co-payments. Under this there are no guarantees that beneficiaries will have the same benefits that they receive today. It allows plans to impose greater cost-sharing requirements on beneficiaries.

Other Comments

In the past, when the Federal government cut back on reimbursement to providers, providers used to be able to transfer some costs to other payors. However, as managed care plans and most insurance companies negotiate to reduce their reimbursement rates, it is harder for providers to cross-subsidize as was previously common.

Many HMO's have elected not to participate in Medicare managed care plans because the per-member, per-month premium is so small, particularly in many upstate areas such as Tompkins County.

Many proposals claim that they are offering patients more choice in their health care. However, as one local advocate noted: "About choice – most people want to be able to choose their doctors, including specialists, but otherwise don't want a huge array of choices. Choice often seems to be the politician's way of saying: "if you have more money, you can "choose" to get more services." If you don't have the money, the so-called choices tend to be meaningless."

[10] American Association of Homes and Services for the Aging, Washington Report, May 17, 1999

E. Outpatient Prescriptions are not covered by Medicare

Seniors typically pay for outpatient prescriptions in the following ways:

- Out-of-pocket
- Medigap plans
- Employer retiree policies (Some companies specifically provide only prescription subsidy because this is a significant cost not covered by Medicare.)
- AARP plan with savings of about 40%
- The Veterans Administration mail-in plan

As more insurance plans secure preferred, lower-cost contracts for drugs, this has increased the cost of drugs for non-contracted groups, such as seniors.

"Despite the indisputable importance of prescription drugs to health care today, Medicare does not explicitly cover outpatient prescription drugs. As a consequence, nearly 15 million Medicare beneficiaries lack drug coverage altogether – many of whom are middle income. . . . An AARP study found that beneficiaries with incomes below $10,000 spent an average of 8 percent of their income for drugs (President Clinton's report).

Subsidy Programs

EPIC, (Elderly Pharmaceutical Insurance Program epic@health.state.ny.us), in New York State allows eligible seniors to purchase prescription drugs at reduced costs. In Tompkins County only 564 seniors are currently enrolled even though an estimated 3,534 are potentially eligible based on their income. The County Office for the Aging can help people enroll in EPIC.

Sometimes if people write the drug company directly, or ask the pharmacist to help, the drug company will provide the medicine free.

A program operated by 85 drug manufacturers offers some medications at no cost or reduced cost to those who meet financial criteria for assistance. Information on this program is available online from The Institute Fulfillment Center at www.institute-dc.org/prescrip.htm. For a paper copy send $5 to Institute Fulfillment Center, Prescription Drug Booklet #PD-370, P. O. Box 462 Elmira, NY 14902-0462.[11]

F. Long Term Care relies mostly on private resources

More than 25% of people over 65 will eventually need some type of long term care. Family and friends continue to provide a significant amount of personal care for individuals. Additional care can cost from $12,000 - $60,000 or more per year.

In the United States in 1990, **long term care** was financed by the following sources:[12]

Source	Percent
Private Individuals	48%
Medicaid	45%
Other	4%
Medicare	2%
Private Health Insurance	1%

Local nursing homes and home health agencies are dependent on third-party reimbursement because they do not have large endowments and the trend is toward fewer private pay patients. In Tompkins County in 1996 the sources of payment for nursing home residents were:

[11] Neighborhood Legal Services newsletter and the Ithaca Journal, July 22, 1999
[12] Health Care Financing Administration, U.S. Dept. of Health and Human Services

Medicaid	69%
Medicare	9%
Private pay	21%
Other	1%

Long term care insurance policies are becoming more readily available to assist with nursing home and home health care payment but very few people to date have purchased this coverage. While the NYS Governor has recommended that more people buy such a plan, long term care insurance plans are primarily cost-effective only for people in the upper-middle income ranges.

Medicaid Funding

The State continues to cut Medicaid reimbursement rates for long term care (and acute) services and has proposals to limit the number of hours of service. In 1996, Medicaid expenditures for Tompkins County residents for long term care were:[13]

Skilled Nursing Facilities	$10,468,703
Hospice	22,685
Personal Care	262,199
Home Health Services	365,973
Long Term Home Health Care Program	65,281

G. Financial Barriers to Health Care

According to a 1995 Tompkins County Office for the Aging survey of a representative sample of County residents 60 and older:

5.2% reported having difficulty in obtaining needed health care services. 41.7% of these people had incomes below 150% of poverty. 45% of these cited

[13] Tompkins County Department of Social Services

financial problems as the reason for having difficulties, and 12.5% of this group said that they could not get in to see a physician.

Extrapolating these percentages to the senior population as a whole results in approximately **265 people citing financial problems** as causing difficulties in obtaining needed health care services.

H. Help in sorting through the options

Both the Federal Medicare office (Health Care Financing Administration) and the New York State Insurance Department have many booklets describing Medicare coverage and other insurance options. However, these are not always easy to decipher. Many providers supply additional consumer information to help their patients navigate the system.

Appeals process

Medicare has an appeals process for people to appeal a denial of payment for a service that has been provided. In general many of the appeals filed have been settled in favor of the patient.

Other Resources

In addition, several local agencies provide individual assistance with information about: 1) choosing health insurance plans, 2) appealing denials of care and 3) eligibility for various subsidy programs.

The primary agencies in Tompkins County are:

- HIICAP (Health Insurance Information, Counseling and Assistance Program) for free, confidential, accurate, and unbiased health insurance counseling. Trained staff and volunteer counselors can explain the coverage, costs, comparisons and options of Medicare, Medicaid and private insurance, including Medigap and long term care insurance. They can also assist with

the filing of claims and point out any duplication of coverage. It is a program of the Senior Citizens' Council.

- Long Term Care Services (LTCS) of Tompkins County can assist individuals and families with their long term care needs. Their goal is to coordinate needed services for a person to remain safely at home by developing a thoughtful care plan which utilizes family, friends, community and agency supports. When remaining at home is not desired or safe, assistance is provided with the process of deciding which housing alternative is available, appropriate, and affordable.

- The County Office for the Aging (COFA) has many services which can help:

  - Their Caregivers' Resource Center provides information and support including information about financial options and health insurance claims.

  - Contracts with Neighborhood Legal Services can provide free legal consultation in civil matters for Tompkins County residents over 60. NLS helps with non-criminal legal problems, primarily in the areas of income maintenance (including welfare, food stamps, SSI, and Unemployment Compensation) and housing (mostly evictions and utility shut-offs or lock-outs). They can also help with health insurance claims.

III. Action Recommendations

The area of health care financing for seniors is largely dependent upon policies and coverage which are decided at the national level. The Task Force has recommended action to influence the national level and also suggested steps we can take here locally.

We need to make sure that the action recommendations are framed in the context of Federal and State legislation and proposals, including the problem of cuts to providers with the Balanced Budget Acts and the increasing difficulty of Medicaid clients finding providers willing to take them.

It is recommended:

A. THAT Congressional representatives be educated about the unmet needs of seniors under Medicare.

B. THAT a packet of information be developed for employers to give to (near) retirees and for the Social Security office to give with their information. Stress that this information can also be helpful to younger employees who may have parents needing this info.

C. THAT an information package be developed for various people (office managers, billing staff, and advocacy groups) to provide to patients.

D. THAT EPIC booklets are continually stocked at pharmacies and physician offices (talk with office managers group). Include information about other sources of help to pay for medications.

E. THAT ideas be developed on expanding access to dental care.

F. THAT methods of communicating that Medicare doesn't cover or only partially covers many needed services be developed to be directed at both seniors and the general public.

G. THAT collaboration occur with the local VA to encourage publicity on veterans' services.

H. THAT community outreach be expanded to let eligible people know about various supplemental insurance programs. (Perhaps especially to the 814 seniors who receive property/ school tax exemptions and the 420 seniors in HEAP.)

I. THAT public information and outreach efforts be coordinated to result in more pro-active and efficient delivery of information.

J. THAT changes be monitored in the Health Care Reform Act and the Balanced Budget Amendment to assess how they affect care for seniors.

K. THAT details about the QMB, SLMB, HIICAP and LTCS programs be included in Senator Seward's existing Senior Citizen Guide to Health Care. In addition, details about the QMB, SLMB and LTCS programs should be included in Senator Seward's guide to Medigap Insurance.

Appendix A

Medicare Part A and Part B Premiums and Coverage[14]

Medicare Part A	**Premium**	**Qualifications**
	Free	- if over 65 and are receiving/eligible for retirement benefits from Social Security or Railroad Retirement Board - if you or your spouse had Medicare-covered government employment - if under 65 and have received Social Security benefits for 24 months, have received Railroad Retirement disability benefits for the prescribed time and meet the Social Security Act disability requirements, or have End-Stage Renal Disease
	$170/mo.	- do not qualify for free premiums and have 30 to 40 quarters of Medicare-covered employment
	$309/mo.	- do not qualify for free premiums and have less than thirty quarters of covered employment
Medicare Part B	$43.80/mo.	Everyone must pay a premium for Part B. This is the amount for 1998.

Medicare Covered Services:

Medicare Part A Example			
Services	**Benefit**	**Medicare Pays**	**Patient Pays**
Hospitalization Semiprivate room, general nursing, services, and supplies	First 60 days 61st to 90th day 91st to 150th day + 150 days	All but $764 All but $191 a day All but $382 a day Nothing	$764 $191 a day $382 a day All costs

Medicare Part B Example			
Services	**Benefit**	**Medicare Pays**	**Patient Pays**
Medical Expenses Physician services, physicals, diagnostic tests, inpatient and outpatient medical and surgical services, occupational and speech therapy, durable medical equipment	Unlimited if medically necessary.	-80% of approved amount (after $100 deductible) -50% of outpatient mental health -$720/year for PT and OT	-$100 deductible -20% after deductible -50% of outpatient mental health

[14] "The 1998 Guide to Health Insurance for People with Medicare," HCFA.

Appendix B

The basic benefits included in every Medigap plan are:

- Part A coinsurance;
- Coverage for 365 additional hospital days after Medicare benefits end;
- Part B coinsurance; and
- The first three pints of blood each year.

This chart shows the features of the **standard Medigap plans.**

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	√	√	√	√	√	√	√	√	√	√
Skilled Nursing coinsurance			√	√	√	√	√	√	√	√
Part A Deductible		√	√	√	√	√	√	√	√	√
Part B Deductible			√			√				√
Part B: Percent of excess actual charge over allowable charge						100% √	80% √		100% √	100% √
Foreign Travel			√	√	√	√	√	√	√	√
At-Home Recovery				√			√		√	√
Basic Drugs ($1,250 limit)								√	√	
Extended Drugs ($3,000 limit)										√
Preventive Care					√					√

Note: There are also two high-deductible ($1,500 out-of-pocket expenses) plans based on plans F and J.