PacificCPE

COURSE
82257A

Medigap, Medicare Advantage, and Medicaid Coordination

Original Medicare doesn't cover everything, and most clients will need to evaluate supplemental options. This course explores Medigap insurance policies, Medicare Advantage plans under Part C, and how Medicaid interacts with Medicare for clients with limited income and assets. Understanding the differences between these options—and the financial implications of each—is critical for helping clients make smart coverage decisions. Tax and financial professionals advising retirees or clients nearing Medicare age will gain the practical knowledge needed to navigate these layered and often confusing program choices.

CREDIT HOURS **2** | FIELD OF STUDY **BUSINESS** | EXAM QUESTIONS **10**

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Assignment

- Study the full course materials included here.
- Complete the review questions after each chapter.
- Answer 10 final exam questions.
- Final exam is scored immediately, 70% or better passes.
- Certificate of completion is available in your account.
- Failed exams can be retaken free of charge.

Course Objectives

- Recognize the benefits of medigap plans.
- Identify the differences between the various Medicare Advantage plans.
- Identify the services covered by Medicaid.

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Chapter 1: MEDIGAP INSURANCE

Chapter Objective

After completing this chapter, you should be able to:

- Recognize the benefits of medigap plans.

Even for people who have coverage from both Medicare Part A and Part B, a serious illness or injury can cause financial havoc because of the bills Medicare leaves unpaid. About a quarter of all Medicare recipients age 65 and older respond to this risk by buying a private supplemental health insurance policy known as "medigap" insurance.

The term medigap comes from the fact that these insurance policies are designed to cover the gaps in Medicare payments. Unfortunately, even medigap coverage leaves some medical costs unpaid.

As an alternative, Part C Medicare Advantage plans typically provide broader coverage at a lower cost than the combination of traditional Medicare Part A and B plus a medigap policy (see Chapter 2). However, Medicare Advantage managed care plans restrict the doctors and other providers available to you. And in recent years, some Medicare Advantage plans have been raising enrollee costs, reducing coverage, and dropping coverage entirely in many areas, adding an element of risk to the Medicare Advantage option.

Before choosing one type of coverage or another, compare benefits and approaches and measure your preferences against the price you would have to pay for each.

This chapter gives you guidance about the gaps in Medicare that need to be filled, and the types of medigap insurance policies that exist to partially fill them. Chapter 2 covers the various types of Medicare Advantage plans available as alternatives to medigap supplements. Before selecting either a medigap policy or a Medicare Advantage plan, review the advantages and disadvantages discussed in Chapter 2, and use the charts at the end of that chapter to compare the costs of and coverage provided by individual policies and plans.

As with other decisions about Medicare and related insurance coverage, you can get excellent, free counseling regarding medigap insurance from your local office of the State Health Insurance Assistance Program (SHIP), also known in some states as the "Health Insurance Counseling and Advocacy Program" (HICAP).

Insurance From Continuing or Former Employment

Many people who become eligible for Medicare at age 65 continue to work and have health insurance through their employers. Many others have health insurance through a spouse's employer.

And many other people keep their job-related health insurance after they retire, as part of their retirement benefits packages, although they usually have to pay much more than current employees pay.

Most employment-based health plans require you to sign up for Medicare Part A when you turn 65, but cover your hospitalization in conjunction with Medicare. Most plans based on current employment don't, however, require you to sign up (and pay for) Medicare Part B, but many retiree plans do require you to enroll in Medicare Part B. The health benefits or human resources office at your work or union can explain the details of coordinating coverage between the employer's plan and Medicare.

The fact that you're eligible for a work-related health plan, however, doesn't mean that you have to continue with it. Work-related health insurance has become more expensive and less comprehensive for employees—particularly retired employees. You might find that Medicare plus a medigap policy and a Part D prescription drug plan, or Medicare through a Medicare Advantage managed care plan with drug coverage, provides you with as good or better coverage at a better price than your employer-based medical insurance does.

Even if you decide not to participate in the regular health plan offered in your workplace, your employer's insurance company might offer you a different policy with limited coverage for some services Medicare doesn't cover at all, such as prescription drugs, dental care, or hearing aids. Compare such a policy with the medigap policies and managed care plans discussed in this chapter and the next to see which one offers you the best coverage for your money.

GAPS IN MEDICARE

When considering the kinds of supplemental coverage available, keep in mind the specific gaps in Medicare payments that you're trying to fill. Medicare coverage is explained in detail in Chapter 1 of course 82255A, but some of the most significant things it doesn't cover, or covers but only partially pays for, are listed below.

Gaps in Part A: Hospital Insurance

Medicare Part A covers almost all the cost of most hospital stays. Its most common gap is the deductible, which everyone must pay before Medicare pays any part of a hospital bill. A much less

frequent but much more frightening gap is the daily coinsurance amount for hospital stays of longer than 60 days. All of the gaps are listed below.

Hospital Bills

Medicare Part A hospital insurance doesn't pay the following costs during a hospital stay:

- A deductible for each benefit period—$1,736 in 2026
- A daily coinsurance amount ($434 in 2026) for each day you're hospitalized more than 60 days and up to 90 days for any one benefit period
- A daily coinsurance amount ($868 in 2026) for each day you're hospitalized
- Anything past a hospitalization of 150 days
- First three pints of blood, unless replaced, or
- Anything for medical costs during foreign travel.

Skilled Nursing and Rehabilitation Facility Bills

Medicare Part A doesn't pay the following costs during a stay in a skilled nursing or post-acute rehabilitation facility:

- A coinsurance amount of $217 per day for each day (in 2026) you're in the facility more than 20 days and up to 100 days for any one benefit period, and
- Anything for a stay of more than 100 days.

Home Health Care

Medicare Part A doesn't pay the following costs for home health care:

- 20% of the approved cost of durable medical equipment or approved nonskilled care, and
- Anything for nonmedical personal care services.

Gaps in Part B: Medical Insurance

Medicare Part B leaves some very large gaps in the amounts it pays doctors and other outpatient providers, depending on whether the doctors or others accept assignment. Everyone with Part B faces the 20% of the Medicare-approved amount that Medicare doesn't pay. And if your doctor or other provider doesn't accept assignment, you're also responsible for up to 15% more than the amount Medicare approves. (See "How Much Medicare Part B Pays" in Chapter 1 of course 82255A for more on Part B payments.)

Medicare Part B doesn't pay the following costs for doctors, clinics, laboratories, therapies, medical supplies, or equipment:

- A yearly deductible ($283 in 2026)
- 20% of the Medicare-approved amount

- 15% above the Medicare-approved amount if the provider doesn't accept assignment
- 20% of the total charges for some outpatient hospital services
- 20% of the approved cost of durable medical equipment or approved nonskilled care, or
- Anything for nonmedical personal care services.

STANDARD MEDIGAP BENEFIT PLANS

The federal government regulates Medicare supplement (medigap) insurance policies—and insurance companies can't offer medigap policies that duplicate Medicare's own coverage.

You can choose among the 10 currently available standard medigap plans. The standard policies are specifically tailored to Medicare coverage, each one filling a certain number of Medicare's gaps.

Important Changing Landscape for Medigap Policies

As of 2010, new medigap policies in original plans E, H, I, and J are no longer sold, but people with existing policies under those plans can continue them. People who continue with these policies should be aware, though, that their premiums are likely to rise more steeply over the coming years because there will be increasingly fewer people enrolled in these plans.

In addition, some of the plans are subject to small changes from year to year. For more information on these changes and the coverage provided under each plan type, see "Descriptions of the Standard Medigap Plans," below.

Caution!

Delay may limit your choices. Insurance companies would be happiest if they could sell coverage only to healthy people. When you're shopping for a medigap policy, you might find it hard to buy a policy if you're already ill and didn't buy a policy when you first became eligible. (The Affordable Care Act eliminated preexisting condition limitations for regular private insurance, but not for medigap.)

The federal government has, however, established some protections for people buying medigap policies, depending on when and under what circumstances you apply. You'll receive the most coverage options if you apply within the first six months after you begin your Medicare Part B coverage. In a few other circumstances, you might also have options to purchase some, though not all, medigap policies without fear of being turned down because of your preexisting condition. If you wait too long to apply for a policy, however, the insurance companies are allowed to review your medical records and reject you if they consider you a bad "profit risk." (To understand the rules regarding your right to purchase a medigap policy, see "Terms and Conditions of Medigap Policies," below.)

Medigap Doesn't Cover Long-Term Care

Many older people fear the possibility of living out the final years of life in a nursing home. The prospect of nursing home life itself provokes distress for many, as does the financial ruin that can be brought about by the cost of long-term care. Unfortunately, neither Medicare nor medigap supplemental insurance nor managed care health plans protect against this potentially enormous cost. Medicare covers only a limited period of skilled nursing facility care and covers nothing of long-term custodial, nonmedical care in a nursing home. Medigap policies and Medicare Advantage plans similarly fail to cover long-term nursing home care.

Long-term care at home is increasingly an option for people who in years past would have been forced to enter a nursing home. More services are available at home, and more agencies and providers offer home care. However, while Medicare and medigap policies cover some short-term home health care, neither covers long-term nonmedical home care.

There's a type of private insurance that can cover some of the cost of long-term nursing home or at-home care. Referred to as "long-term care insurance," it's available in a variety of benefit packages but comes with numerous restrictions and exclusions. The cost of these policies varies greatly, depending on the extent of coverage and the age of the person purchasing the plan. Medicaid also covers some long-term care costs.

Not every insurance company offers every medigap plan. And only the benefits included in each standard category of plans are standardized. Other important aspects—premium increases and preexisting illness exclusions, for example—vary from policy to policy and require careful comparison shopping.

When you consider medigap policies, your task is to see how many of the gaps in Medicare payments you can fill within the constraints of your budget. The broader the coverage in a medigap policy, the higher the cost.

And the cost of a standard policy can vary widely from company to company. So you must determine not only which standardized benefit plan best suits your needs, but which company offers which plan at the best price. Then examine the other elements of each policy, such as premium increases and preexisting illness exclusions, before making your choice.

Basic Benefits Included in All Medigap Plans

All standard medigap policies begin by offering the same basic benefits, including coverage of:

- Hospital coinsurance amounts under Medicare Part A (but not necessarily the deductible)
- 365 days of hospital coverage after Medicare coverage ends
- Some or all of the cost of covered blood transfusions
- Some or all of the Medicare Part B coinsurance amount (the 20% of Medicare-approved amounts that Medicare Part B doesn't pay), and
- Some or all of the out-of-pocket cost for hospice care (for all policies issued on or after June 1, 2010).

Notice that these basic benefits are meant to close gaps in Medicare coverage, not to provide separate medical insurance. If a hospitalization or medical treatment isn't covered at all by Medicare, a medigap policy won't cover any of it, either. The exception to this is those medigap policies that cover foreign travel.

Inpatient Hospital Costs

For each benefit period, every medigap plan pays all your Medicare Part A coinsurance amounts through your first 90 days as an inpatient, plus your coinsurance amount for any reserve days. After your reserve days are used up, every plan pays for the entire Medicare-approved amount of hospital charges for an additional 365 days. All plans pay some amount for the first three pints of blood you receive (Plans A through J pay the full amount; K pays 50%; L pays 75%). All plans except Plan A pay the yearly Part A hospital inpatient deductible (but Plans K and M pay only 50%, Plan L pays only 75%).