Navigating Health Care Insurance with SHIIP

by Melinda Munden, NC SHIIP

Do you work with people who have Medicare? Do you have it yourself? If so, you know that many seniors and younger beneficiaries struggle to understand it and the products associated with it, as well as when and how they should sign up for them.

In 2007, the North Carolina's Seniors' Health Insurance Information Program (SHIIP) received national recognition for the high quality of its performance in guiding Medicare beneficiaries through the complicated process of evaluating Medicare program options, enrolling in those which best fit their needs, and understanding their portion of charges for medical services. More than 800 volunteers, located in senior centers, cooperative extension offices, and county councils or departments on aging, provide services. (Consult the Department of Insurance's website, http://www.ncdoi.com/SHIIP/shiip_county_sites.asp, to find the counselor in your area.)

Almost all people are enrolled automatically in Medicare Part A when they turn 65. However, individuals need to make choices about coverage under Part B or Part D—not only which plan to choose, but whether they have comparable coverage, and so do not need to enroll. For some people, a Medicare Advantage plan (sometimes called “Part C”) may provide the best coverage. Choosing which of the various options best suits a person’s needs can be quite complicated, but SHIIP volunteers are there to help.

A Quick Review and Update about Medical Insurance for Adults Age 65+ and Younger People with Disabilities

Medicare

Medicare is a federally funded health insurance program for people who are age 65 and older and for younger adults who receive Social Security disability benefits or who have End Stage Renal Disease or Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig’s Disease). In February 2010, the Social Security Administration added early onset Alzheimer’s and other dementias (under age 65) to the list of conditions that receive expedited disability determination, and this allows access to Medicare coverage.
There are two parts to Original Medicare, Medicare Part A, which is often called hospital or inpatient/institutional coverage, and Medicare Part B, which is the medical or outpatient part of Medicare. The program is funded by a portion of payroll taxes paid by employees and their employers.

Medicare Part A pays in-patient hospital charges as well as for limited stays in skilled nursing facilities for rehabilitation after hospitalization or for respite for caregivers of people using hospice. It does not pay for long-term care. People do not pay premiums for Part A if they or their spouse have 40 or more quarters of Medicare-covered employment (about 10 years total). Those with fewer quarters pay premiums for Part A, and this may be important to people who have been agricultural or other workers who didn’t participate in the Social Security program earlier in their lives.

People are automatically enrolled in Part A upon turning 65 unless they delay receiving Social Security benefits. It is important to note that the age at which Baby Boomers receive Social Security is rising, but the age for Medicare is not.

Medicare Part B pays charges by physicians and other health care providers, both in the hospital and in the community. To avoid paying a penalty for late enrollment, older adults must sign up for Medicare Part B within three months (before or after) of their 65th birthday month, unless they have a qualifying alternative plan (often through a current or former employer). Monthly premiums for Part B coverage are typically deducted from people’s Social Security checks, and those with an annual income above a certain level pay a higher premium. Medicare Part B has an annual deductible and coinsurance/copayment is required for most services.

Medicare Supplement plans, also known as Medigap plans, are standardized policies sold by private insurance companies that are specifically designed to fill in the coverage gaps in Medicare Parts A and B (e.g., deductibles and copayments). All plans cover a basic group of benefits, but they vary in which gaps they address. Plans are designated by letter codes A through L, so that people can evaluate comparable plans and costs across insurance providers. Medicare Supplement plans do not include prescription drug coverage, and monthly premiums can be costly.

Medicare Part C—Medicare Health Plans or Medicare Advantage Plans—is another option. While many people choose to stay with traditional Medicare, others have found that Medicare Advantage plans cover more services that they need or want. Some of these plans include prescription drug coverage, replacing the need to enroll in Medicare Part D, and others include health maintenance or wellness services, such as vision, hearing, and dental services, that are not covered by Medicare Parts A or B.

Medicare Advantage plans are offered through private insurance companies that receive Medicare funds for managing the health care services of the people they cover. They provide the same benefits offered under Medicare Parts A and B. Services typically require copayments or coinsurance, but many plans also have an annual out-of-pocket maximum and eliminate the need for a Medicare supplement policy. However, no matter what Medicare option beneficiaries choose, they will continue to pay the Medicare Part B premium.

There are four types of Medicare Advantage plans. While all are approved in North Carolina, their availability depends on the county.

- Medicare Health Maintenance Organizations (HMOs) provide all nonemergency services to members through a network of hospitals, doctors, and other providers. Typically, HMOs have small copayments for covered services and require referrals for specialized medical services.
- Preferred Provider Organizations (PPOs) also have a network of medical providers, but they usually do not require a primary care physician’s referral for specialized medical services. PPOs have copayments for medical services received from providers in their network, and higher out-of-pocket expenses for services received outside the network.
- Private Fee for Service Plans (PFFS) provide coverage through a pay-per-service agreement. Participants can go to any Medicare-approved doctor or hospital in the U.S., but it is extremely important for individuals to ask first whether the health care provider will accept the terms and conditions of the plan.
- Special Needs Plans (SNPs) typically limit enrollment to people in specific institutions, such as nursing homes, people who are eligible for both Medicare and Medicaid, or people with certain chronic or disabling conditions.

Individuals can enroll in Medicare Advantage plans during the Medicare Annual Election Period (November 15–December 31), as well as during the Medicare Advantage Open Enrollment Period (January 1–March 31). Medicare Part D pays part of the cost of prescription medications. Medicare beneficiaries who do not have prescription drug coverage through an Advantage plan may want to consider signing up for this insurance. In North Carolina in 2010, there are 47 privately administered Part D plans. Coverage and costs vary
among them, but all must provide at least a minimum level of coverage set by Medicare, including catastrophic coverage. Monthly premiums range from $17.10 to $103.80 in 2010, and plans have a yearly deductible, copayments, and coverage gap, although the Health Care Reform Bill will reduce this gap in 2011 and it should be eliminated entirely by 2020.

People can review their drug plan between November 15 and December 31 each year to determine what plan best suits their needs for the following year. Plans cover different combinations of medications, and the annual opportunity to review the plan allows people to be sure they have coverage for any new medications they may be using.

North Carolinians age 65 and older may qualify for the state pharmacy assistance program, NCRx, which will pay up to $29 toward the monthly Part D premium, and there are other programs described below to help people get Part D coverage.

**Medicaid**

Medicaid is a state-federal partnership to provide health care for people who are categorically needy (income under a certain level) or medically needy (greater income, but whose medical care is very costly).

Medicaid has special programs to help people in different income categories get health care coverage under Medicare. For those who meet the most stringent income restrictions, Medicaid pays the Medicare premiums, deductibles, and copayments and provides additional coverage for vision, hearing, and dental care. For others who have Medicare and limited income and resources, Medicare Savings Programs can pay premiums, deductibles, and copayments for Medicare Parts A and B. There are three levels of Medicare Savings Programs assistance, MQB-Q, MQB-B, and MQB-E, which cover individuals or couples in progressively higher income tiers (up to $1,219 and $1,640, respectively). Applications for Medicare Savings Programs are processed through county departments of social services.

**“Extra Help” or the Low Income Subsidy (LIS) to help with Part D.** People who qualify for the Medicare Savings Programs automatically qualify to receive what is called Extra Help with their Medicare Part D plans, which reduces their monthly premiums for coverage, lowers copayments for generic and brand name drugs, and keeps them from falling into the coverage gap known as the “doughnut hole,” where they would be responsible for the entire cost of drugs until they reach a certain annual out-of-pocket expenditure.

Although this program’s first focus is people who are eligible for Medicaid, Medicare beneficiaries with higher incomes can still file an application for Extra Help through the Social Security Administration. In 2010, the income and resource limits are $1,353.75 per month with resources up to $12,510 for an individual, and $1,821.25 per month with resources up to $25,010 for a married couple.

In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) gave new emphasis and support to Extra Help in hopes of helping more people. Beginning in January 2010, the resource limits for the Medicare Savings Programs increased to match the full Extra Help/Low-Income Subsidy (LIS) level. Also, the Social Security Administration no longer counts as income the help a person regularly receives from someone else to pay for household expenses such as food, mortgage, rent, heating fuel or gas, electricity, water, and property taxes, nor do they count life insurance policies as a resource.

With the applicant’s consent, the Social Security Administration is also transmitting Extra Help/LIS application data to states, so the states can reach out to people who might be eligible. Because of these changes, SHIIP has embarked on a new partnership with the North Carolina Division of Social Services called Relay for Extra Help, to identify people who may qualify for Medicare Savings Programs and for Extra Help. County departments of social services were asked to assign a DSS–SHIIP Liaison to work closely with their local SHIIP coordinating site to make the most of their combined efforts. Liaisons attend local SHIIP meetings and coordinate local efforts to assist Medicare beneficiaries during the application process. In April 2010, 99 county DSSs had assigned a SHIIP Liaison.

**What about long-term care?**

Individuals and families are largely responsible for paying for long-term care, whether in their own homes, in assisted living, or in a nursing facility. In 2009, the cost for nursing care in North Carolina was $60,000 to $63,000 per year and about $10,000 higher in metropolitan areas. Assisted living was about $26,000 outside the metropolitan areas, but as high as $44,000 in the Raleigh area. (http://www.genworth.com/content/genworth/us/en/products/long_term_care/long_term_care/cost_of_care.html)

As mentioned before (and repeatedly), Medicare does not pay for long-term care. The benefits for skilled nursing care are for acute care and have short time limits.

**Long-term care insurance** is designed to pay some or all of the costs of nursing home, community, or home health care for people who cannot meet the needs of everyday living on their own or with help from family and friends. While long-term care insurance can be costly and may not cover all expenses, it can help safeguard assets and protect a person’s financial stability. One important decision that people who are ag-
ing face is whether to buy long-term care insurance. Weighing the costs and benefits, as well as evaluating plans, is another thing SHIIP volunteers can help to do.

**Without Volunteers It Could Not Be Done**

SHIIP has a volunteer base of 110 county coordinators and more than 800 volunteers to assist the 1.3 Medicare beneficiaries in North Carolina. Volunteers for SHIIP must successfully complete a 24-hour training course to become certified, they are required to attend quarterly follow-up training, and they must provide 40 hours of counseling services annually to maintain their certification. Without these remarkable people, SHIIP could not reach out to all of the Medicare beneficiaries in our state.

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**Celebrating Lives Through Person-Centered Practices**

Join us for the North Carolina Conference on Person-Centered Practices! Here is the tentative agenda for the day.

- **8:00 AM** Conference Registration and Breakfast
- **9:00 AM** Opening and Welcome
- **9:25 AM** Success Stories
- **10:00 AM** Breakout Sessions (Four concurrent 60-minute sessions, attend two)
- **12:15 PM** Lunch (included in registration, as are morning and afternoon breaks)
- **1:30 PM** Breakout Sessions (Two concurrent)
- **2:40 PM** Building Person-Centered Organizations (Panel)
- **4:00 PM** Celebrating Lives Through Person-Centered Practices

Among the topics for the breakout sessions are:
- Grandma Stole My Ipod: Technology and Person-Centered Practices
- Overview of the MH/DD/SA Planning Process
- Updating the MDS: Person-Centered Care in Nursing Homes
- The Purpose Triangle: Aligning Values with Work
- 1 Life, 1 Page, 1 Heck of a Great Tool! Using 1-Page Descriptions Every Day
- Painting Caregivers and Communities into the Person-Centered Picture
- Developing and Maintaining Person-Centered Learning Communities
- Capturing What Matters: Person-Centered Tools for Individual Planning
- Keeping the Fires Burning: Person-Centered Learning Communities

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The aspen is perhaps the world’s largest organism. Although some aspen forests cover acres and seem to be composed of individuals in all stages of life, they share a common root system.