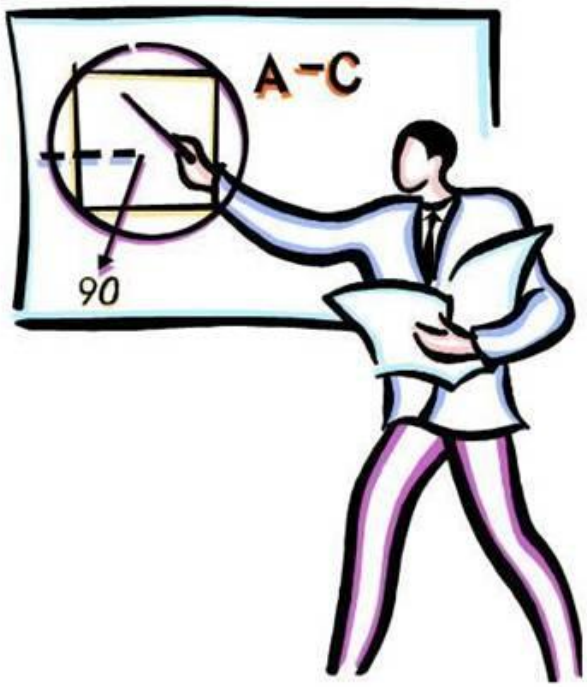
Understanding Medigap



Understanding Medigap

By Timothy Barnes, CLU

TABLE OF CONTENTS

SECTION I – ARTICLES

SECTION II -FAQS

Preface

This book was written while I was wearing my Insurance Counselor's hat and not my Insurance Agent's. The difference may be subtle. I assure you, there is a difference.

The job of the insurance agent is to work in the best interests of the insurance company he represents. In other words, sell, sell, and sell!

The Insurance Counselor is an employee of the client. He is paid directly by the client for his counsel and advice. This is one reason for the nominal charge for this book. The insurance companies do not pay me. I am free to offer my honest opinions about insurance.

In this book I offer my professional opinion about a type of insurance that is available. No insurance companies are mentioned by name. If, after reading this book, you decide that Medigap is right for you; I encourage you to take the following steps.

1) Read the CMS publication, "Choosing a Medigap: A Guide to Health Insurance for People with Medicare."

2) Only after you have decided which Medigap plan you want, work with a qualified insurance agent, whom you trust, to apply for Medigap.

3) When you receive the policy, make certain you take the time to read it. Make certain that it is the plan you wanted and that you understand your responsibilities. You should make the most of your insurance.

Section I of this book is a collection of articles that have been written about Medigap in the last year. You will find some repetition between the articles. That is because that repetition of a fact helps with the learning process. The more times you hear a fact, the higher the likelihood that you will retain that information.

Section II of this book is a collection of Frequently Asked Questions. As an Insurance Counselor, I get asked some excellent questions from time-to-time. I think that these questions should be asked more often. Many times, people do not even know what questions they should ask about their health insurance until it is too late.

The FAQs in this section are questions that clients have asked me in the past. I hope you find them helpful. As this book is published electronically, I am able to update the FAQ section more easily. If you think of a question that should be addressed, please email that question to me at *tim@theinsurancebarn.*com so I can update this book for future readers.

SECTION I - ARTICLES

INTRODUCTION TO RETIREMENT INSURANCE

When you retire your insurance needs will change. You will need to change both the way you think about insurance and what insurance policies you have.

Every person's insurance needs are different. It would be very presumptuous of me to pigeonhole every person and try to make one policy meet everyone's needs. What you will find in this book is information about Medicare Supplement insurance. Your rates will vary depending on several variables. This chapter gives you an idea of what you should be investigating.

Baby Boomers were teenagers during the "Happy Days" of the early 60s. They remember the Beach Boys and Righteous Brothers. As young adults they Dreamed of Jeannie and wondered if

Gilligan would ever get off that island.

They watched in horror, as Walter Cronkite announced the death of President Kennedy. Two years later, they saw his replacement, Lyndon Johnson; sign the legislation that created Medicare.

On January 1, 2010 the Baby Boom generation started to enroll in Medicare. As a group, they are still active and healthy. As they age, their bodies will start to have more problems. Already, the number of knee replacement surgeries is on the rise. After an active lifestyle, Baby Boomer knees are wearing out. As they reach 65 they will have to change how they pay for these surgeries and other medical bills.

Along with other changes during retirement, they will have to pay close attention to their new health insurance. The "free" Medicare they enrolled in when they retired is not free of potential liabilities.

In most cases, Medicare Part B will pay about 80% of your medical bills. You are still liable for deductibles, co-insurance and co-pays. One thing that Medicare Part B does not have that you may be used to, is an Out-of-pocket cap. Whether your medical bills are $ 1000 or $ 100,000 you are responsible to pay 20%.

If your only problem during the year is a twisted ankle, you are doing something right. Accidents can happen to anybody. Accident or not, the E.R. will still charge you. Let's assume the final bill is $ 1162. If you have Medicare B you will only have to pay $ 362. That is $ 162 for the deductible and $ 200 for the co-insurance. Medicare would pay the other $ 800.

A Medigap plan would be an inefficient use of your money for that year. You would be better off to use the money that you would have spent in premiums to pay the doctor directly.

However, if you have to have heart surgery, your portion of the bill will be much higher. You would have to pay the $ 1,132 Medicare A deductible. You would also be responsible for 20 % of your doctor's bills plus the annual Medicare Part B deductible.

Here is where things can get confusing. Medicare A only pays for bills associated with the hospital. Those bills are limited to things like a room, board and supplies. It does not pay your doctor's or surgeon's fees. That is paid by Medicare Part B.

The horror stories you may have heard about high hospital bills after Medicare include Medicare Part B charges as well.

Depending on the Medigap plan you have, Medigap will pay what Medicare does not. You will also need a Medicare Plan D (PDP) to help with your prescription drugs.

In this case, a Medigap plan would pay for itself several times over. It would justify spending money on premiums for those years you do not need it.

A car accident could cost over $ 100,000 in medical bills. Medicare will pay a significant chunk of that but you will still be personally liable for what Medicare does not pay.

The health insurance you used to have probably capped your out-of-pocket liability at around $ 5000 plus your deductible. Assuming you had a $ 2000 deductible at age 64 your total liability for being in the wrong place at the wrong time would be capped at $ 7000.

Medicare has no cap. Do the math for yourself. If the above accident happened to you, it could leave you with a sizeable bill. There are two ways you can pay that bill.

Out-Of-Pocket

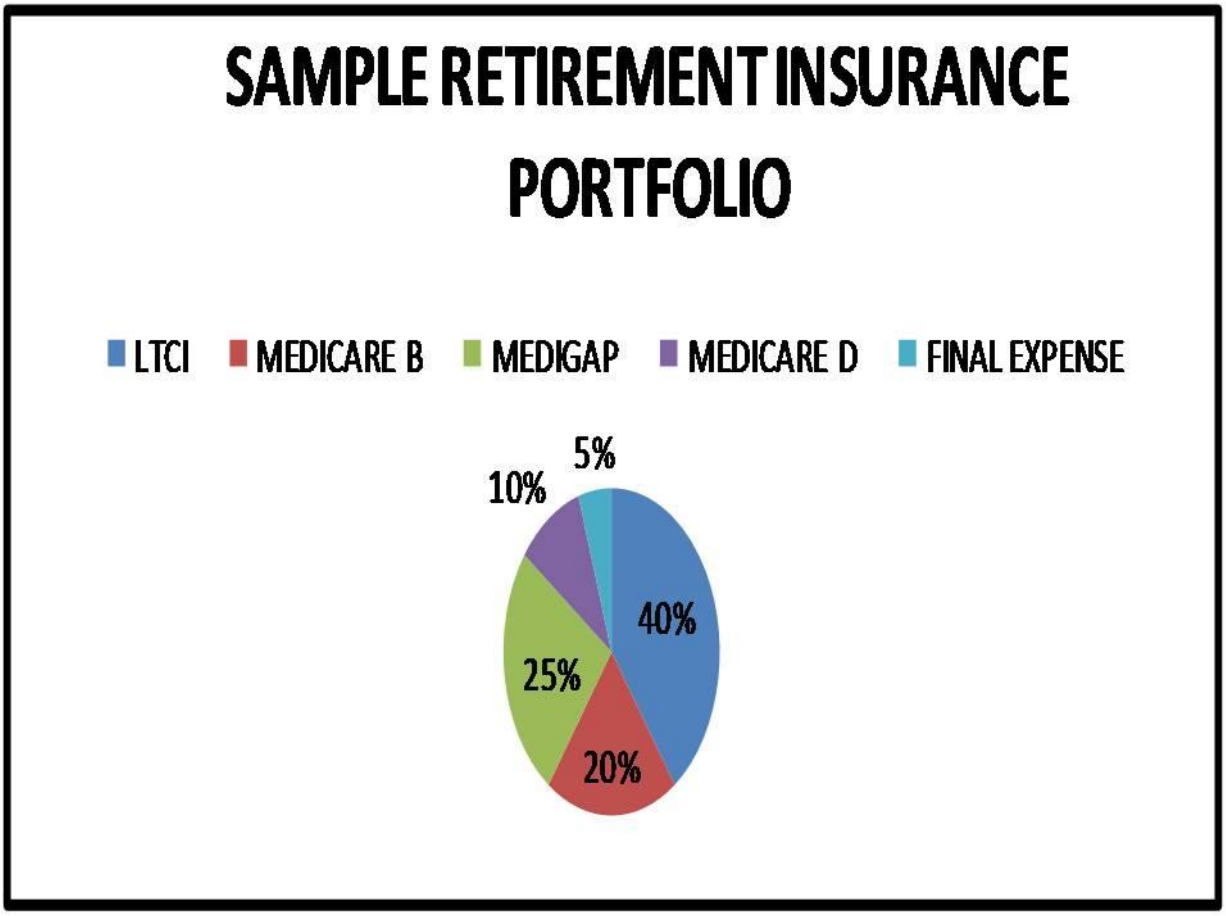
You will be allowed to pay the hospital from your savings. I guarantee that if the money in your retirement savings account spends, the hospital will be glad to accept it. They do not care whether the money comes from an insurance company or your bank. All that matters to them is that they get paid.

If you have no savings, you can possibly make a payment arrangement with the hospital to pay them something from your Social Security or Pension each month. Speak with the hospital's business office. They may be willing to allow you to make installments on your bill. I cannot speak for every hospital but many will.

Insurance

With apologies to the politicians who would have you believe otherwise, you don't have to have health insurance to get health care.

Health insurance is just the most commonly used tool to pay for medical bills. You can use cash if you choose. You didn't really need all that nasty money cluttering up your bank account, did you?



If you elect to use insurance, the chart above illustrates how premiums for a standard retirement insurance portfolio can be used. As you review the breakdown, remember, this is only a sample. Your needs may be different.

The purpose of this chart is not to tell you what percentages to use when setting up your insurance budget. The purpose of this chart is to encourage you to see how all the parts of your insurance portfolio are inter-linked.

Too often I see where people have purchased insurance without considering how it relates the other types of insurance they have. This leads to duplicate insurance coverage in some areas and no insurance protection in others. It also leads to people saying, "I'm insurance poor." When I hear that phrase I know that the odds are 80 % or greater that I am speaking with a person who has not taken the time to analyze their insurance portfolio.

Long Term Care Insurance

Also known as LTCI, Long Term Care insurance pays your home health care, assisted living or nursing home expenses in your future years. After you have considered your probabilities of a

future need for assistance and its cost, you may decide that LTCI is just as important during retirement as Life insurance was during your working years.

Private LTCI is often the most expensive of all the types of insurance you need during retirement. If you wait too long, it could easily be as expensive as all the other insurance products you need, combined. Like life insurance, the younger you are when you purchase it, the less expensive it will be. If you are making financial plans for your retirement years, I highly encourage you to lock in a premium as early as you can.

Since the focus of this book is Medicare Supplement insurance, I will leave the discussion of Long Term Care insurance for another time.

Medicare

Medicare B is the part of Medicare that pays for the largest chunk of your doctor's bills. It is the part of original Medicare that pays your physician's bills for his/her services. It limits how much your doctor may charge for each procedure and pays 80% of that figure after you have paid the annual deductible.

If your doctor does not accept "Medicare Assignment," he/she is free to charge an additional 15% above the Medicare approved amount. This is called an "Excess Charge." I discuss it later in the book.

Part A of original Medicare will cover the hospital bills of all Americans who have paid Medicare taxes during their working years and are qualified for "free" health insurance.

Just be careful. This is where many people get confused. Medicare Part A only covers the bills associated with facilities. It does not cover the charges of doctors and surgeons. Those are only covered by optional Medicare Part B.

Medicare B requires each participant to pay a premium each month. In many cases, people elect to merely have the Medicare premium withheld from their Social Security retirement benefits.

Medicare B's monthly premium is subject to change each year. The amount of your premium will be based on the income you earned 2 years previously. You may be wise to work with your tax preparer when you are 63 - 64 to avoid unpleasant surprises when you are age 65 - 66 if your income borders on one of Medicare's breakpoints.

Medigap

Medigap pays the portion of medical bills that Medicare does not. You can get plans that pay everything. You will never again have to pay anything for medical treatment. Your other option allows you to get a plan that only pays a portion of what Medicare does not. Those plans leave you with a share of the bills. Obviously, those plans are going to be less expensive.

Medicare Supplement is also referred to as Medigap. I try to use the term Medigap as often as possible to avoid confusion with Medicare Part D, (prescription drug plan.) It is also referred to as a Medicare Supplement.

You will have to learn different definitions of terms when you become eligible for Medicare. In the past you were "enrolled" in your health insurance plan at work. Medicare, uses the same terminology but with a different meaning.

Medigap has two "enrollment" periods. During those periods, you are guaranteed approval, regardless of your health. That does not mean that you cannot get Medigap outside of those "enrollment" periods. It just means that your health is a consideration.

Except for Guaranteed and Special Enrollment periods, Medigap plans are subject to medical underwriting. Underwriting criteria is not as strict as it was before you retired. It will, however, eliminate people with severe medical problems. The best bet is to obtain a Medigap when you first enroll in Medicare B during your Guaranteed Enrollment Period.

You are only guaranteed a Medigap plan if you apply during your Guaranteed Enrollment. Your open enrollment for Medigap is the first 6 months you are eligible for Medicare.

If you wait until after that window closes to get a Medigap plan, they are still available assuming you can medically qualify. Your other option for guaranteed approval is to apply during a Special Enrollment Period if you qualify. You will learn what those are later in this book. If you wait until you are sick to get a Medigap, it will be too late.

Here is an insurance hint. As time goes by, you may find it necessary to move from one insurance company to another. Never cancel an existing insurance until a new one has been approved. An application is not the same thing as a policy.

Request an effective date that is a month or two away. Give yourself time to look over the new policy before you cancel your old one. Make certain the new policy meets your insurance needs before you cancel the old one.

Remember, your insurance agent is not supposed to cancel your existing insurance plan without your direct instructions. Most insurance companies require written, signed and dated instructions from the policy-holder before they will cancel a policy. Don't assume your insurance agent will cancel your existing insurance policy for you. You will have to cancel it yourself.

Medigap is Guaranteed Renewable. That means that as long as you pay your premium the policy cannot be taken from you. It does not mean that your premiums are locked in. Your premium is likely to adjust each year. As long as you pay your premium, the policy will continue. Don't be scared by what politicians say. An insurance company cannot cancel a Guaranteed Renewable policy based on the insured's health. That is nothing more than a politician's lie.

If the premium rises too much and your health has deteriorated to the point you cannot pass underwriting with a different insurance company, you may be able to switch to a lower cost plan with fewer benefits within the same insurance company. Talk with your insurance agent of record. He/she may be able to help you with that. If your health is still good, you may elect to shop with a different insurance company. If that is what you elect to do, once again, your insurance agent should be able to help you.

Medicare D

Original Medicare does not pay for prescription drugs. In 2006 the Medicare D program was authorized. It allowed private health insurance companies, under the guidance of CMS, to pay for prescription drugs.

The Medicare D program is similar to the Medicare B program. It is optional and has a premium.

Medicare D is overseen by the Centers for Medicare and Medicaid Services, aka CMS. They are the ones who regulate the minimum plan standards.

Medicare D plans are sold and managed by private insurance companies. Each company is allowed to modify their plans with more generous benefits but they must include at least the minimum benefits mandated by CMS.

Medicare D is similar to Medicare B in that you may elect to forego the plan when you first retire. That may be tempting if you enjoy good health when you first enroll in Medicare. However, it could be a case of being "penny wise but pound foolish."

Both Medicare parts B and D charge a penalty if you opt out of the program when you are first eligible but join the program at some time in the future. You could find yourself paying more in the future when you are bringing in less income. Before you elect not to enroll in Medicare B and D, think very hard about the potential consequences.

Medicare D's initial enrollment is also similar to Medigap. There is a window of time in which you must enroll in the plan if you want it immediately when you become eligible for Medicare. The window is different from Medigap.

If you want Medicare D when you enroll in Medicare you must enroll during the 7 month period that starts 3 months before the month your 65th birthday is in and closes 3 months after the month of your 65th birthday. If you miss that window, you will have to wait until the next Annual Enrollment Period to join the program.

Final Expense

During your employment years you may have needed much more life insurance than you do during retirement. Unless your attorney has advised you to carry life insurance for estate planning needs, you may find that the only "need" for life insurance is final expenses.

A Final Expense life insurance policy is designed to pay only for final expenses when you die. It is not designed to pay off a loan, replace income or pay for the education of your children. If you need that type of life insurance during retirement, contact your insurance agent. I know he/she will be happy to help unless you already have one foot in the grave and the other one in a puddle of oil.

Final Expense life insurance is typically $ 15,000 of whole life insurance or less. It is very possible that the large term life insurance policy you had during your employment years can be converted into a Final Expense policy. If it cannot, your insurance agent should be able to help you find the policy for you at a reasonable price.

Annuity

There is a type of insurance that is not referred to on the chart. It is called an annuity. I know that during your career the term, "annuity," was often used to describe a financial vehicle that allowed you to accumulate money on a tax favored basis. It was the insurance aspects of the product that provided the tax favored growth. Now that you are retired, you may want to start taking some of that money to help with living expenses.

Annuities are used to make certain that you do not outlive the savings that you accumulated during your career. They also have some estate planning benefits that allow you to leave your savings to heirs when you die without increasing the size of your estate for probate.

During your working years you struggled to raise your family, pay your bills and still save for retirement. Some of us have been able to save more than others. When retirement arrives, you may want to guarantee that your savings are not used up before you die. Life annuities convert your nest-egg into a stream of income that lasts for your entire life and the life of your spouse.

When you retire, if your savings are in another type of fixed interest rate investment and you want to guarantee that your life savings will not evaporate during your life, you may want to consider if an annuity fits within your retirement plan.

On the pages that follow you will find information about the most popular Medicare Supplement plans. This discussion is limited to the more popular plans that are available in the states in which The Insurance Barn operates. For a more thorough discussion of Medigap I would refer you to the CMS publication, "Choosing a Medigap Plan: A Guide to Health Insurance for People with Medicare."

If you do not have a copy of that booklet available, it is available for free download on http://theinsurancebarn.wordpress.com/ .

MEDIGAP PLANS

The Center for Medicare Services (CMS) has approved two new Medicare Supplement plans for sale as of June 1, 2010. These new plans are labeled M & N.

Details about M & N can be found in the CMS publication, "Guide to Health Insurance for People with Medicare."

Plan M has not proven to be very popular. There are fewer than 1,000 policies in the entire nation. Plan N, however, is a different story. It has proven to be immensely popular.

There are several similarities between plans F & N but there are a couple of major differences

1. Plan F pays Medicare B deductible. Plan N does not.
2. Plan F pays if the doctor/hospital charges more than Medicare allows. Plan N does not.
3. Plan F is much more expensive than plan N.

Each Medicare recipient will need to decide for him/her self which plan is best. If there are any remaining questions, ask an insurance agent that you trust. He/she deals with Medicare supplement insurance daily. He/she can explain the differences between plans for you.

Just remember, you need to remain in control of the purchase. Buy what is best for you and not what the agent wants to sell you. The best way to do that is to study the Guide to Health Insurance for People with Medicare before speaking with an agent. Turn him/her from a sales person to an order taker. He/she is paid a commission each time you make a premium. That commission varies from company to company depending on which product is purchased.

In other words, the agent is biased. The more specific you are in what you want, the less biased he/she is going to be. Don't tempt your insurance agent more than is necessary. Know what you want before you speak with him or her.

Are you about to retire but already feel insurance poor? Do you think your only options are to rely on Medicare only or pay through the nose for Medigap?

Medicare is a wonderful program but it does have some loop holes that could be expensive for you if you were to be in an accident or experience a serious injury.

<u>Prescriptions</u>

Regular Medicare does not cover your prescription medications outside of the hospital. In order to get that type of coverage you have to have a separate, optional plan called Medicare D.

Medicare D is the most recent addition to Medicare and the most popular. During the Health Care Debates of 2009 – 2010 it was a major point of contention. Confusing words like "Donut Hole" and "Coverage Gap" were tossed around by politicians and political activists.

There is no escaping that some seniors will see what they are paying for prescription drugs during the last few months of the year decrease if they participate in the Medicare D plan. With

all the posturing made by politicians against private health insurance companies, it is important to remember that Medicare D plans are only available through private health insurance companies.

Pretending there is no cost to seniors for prescriptions is misleading. In order to participate in the Medicare D plan you must pay a premium to a private health insurance company. The average monthly premium is currently a few pennies over $ 31 a month. That is $ 372 a year that participants have to pay towards prescription medications.

In addition to the monthly premium, many plans have a Medicare required deductible for Brand Name drugs. An insured person is out almost $ 500 before their prescription insurance will pay anything towards certain Brand Name Drugs.

Even with your Medicare D card, you will have to pay a "co-insurance" or "co-pay."

The difference between "co-insurance" and "co-pay" is a little technical and better suited for another time. Suffice it to say that even if you participate in Medicare D you still have to pay something for your prescriptions to the pharmacy.

Medigap

Original Medicare will pay most of your medical expenses. Be careful to remember that "most" is not "all." Medicare leaves you the responsibility to pay the initial deductibles and coinsurances.

There is no limit on the amount Medicare will pay for you. There is also no limit on the amount the 20% coinsurance can add up to.

Although Medigap plans are sold by private health insurance companies, the plans have been standardized and prepared by the Centers for Medicare and Medicaid Services (CMS). Whether you purchase your plan from ABC Company or XYZ the policies will be identical. Everything will be the same on your policy except for the logo and contact information of the insurance company you have chosen.

CMS has designated a letter of the alphabet for each Medigap plan. The most recent additions are plans M and N. Plan F is the most comprehensive and plan A is the most restrictive plan.

You may have heard from others about plans that supplement Medicare and pay for prescriptions at the same time. Such plans exist for those who already have them but they are considered obsolete. Plans, like plan J have been retired and are no longer available for new purchase.

If you are retiring today and want to supplement Medicare you will need to obtain both a Medigap and Medicare D plan. It may be more paper work than it used to be but it is much, much less expensive.

One strategy to holding down the costs of your Medigap plan is the High-Deductible Plan F option. Not every insurance company offers it. For those who can get it, it is often the least expensive of all Medigap options.

The regular Plan F is comprehensive coverage from the start. Each year it pays the deductibles and co-insurance for both Part A and Part B. A person with a traditional Plan F should have few, if any, medical bills in a given year...

The High-Deductible Plan F will pay exactly like the regular Plan F with one exception. In exchange for a much lower premium, the insured agrees to pay the first $ 2000 of Medicare approved expenses each year.

If you are willing to pay you medical bills out of your own pocket, the High Deductible Plan F may be a great option for you to consider. The monthly premiums are very affordable. It will preserve your savings if something major were to occur.

On the other hand, if you normally have several medical bills and want something to help you, regular Plan F may be a nice fit for you. Since it pays both Medicare deductibles plus the 20% of the bills Medicare does not pay, you should never have to worry about keeping track of medical bills if you are using doctors and hospitals who accept Medicare Assignment.

If you want to review what each plan covers, look at the official CMS publication, "Choosing a Medigap Policy: a Guide to Health Insurance for People with Medicare."

MEDICARE ADVANTAGE AND PART D ANNUAL ENROLLMENT PERIOD

In the wake of the PPACA some insurance companies have lowered their premiums for Medicare Advantage plans. The same report that mentions the lower premiums also mentions that some insurance companies have withdrawn from the Medicare Advantage program. Some have lowered their premiums because they are offering fewer benefits. Others are still providing the same benefits but charge a higher premium.

Advantage

If you or your parents participate in the Medicare Advantage program, make certain you read the fine print in everything you receive. Don't ignore anything or assume that everything will remain the same in the future. When the open enrollment closes for the next calendar year, you must live with your election for that year.

If you read your renewal offer and find everything is acceptable, you need do nothing. If you read your mail and discover that your Advantage plan has been discontinued or altered, you only have 6 weeks in which to make changes.

Medicare D

In the past, many companies have offered multiple plans. Each plan had a different premium. As long as each policy meets the minimum standard mandated by CMS, insurance companies are free to offer more exhaustive plans. Obviously, the more benefits a plan offers, the higher the premium is going to be.

People who do not take any prescription drugs may be satisfied with a basic plan. On the other hand, people who take several prescription drugs may want a more comprehensive plan.

At this point in time, the best advice I am able to give my friends and clients is to make certain you read everything you can get your hands on about the Medicare D plan in which you are interested.

If you are currently enrolled in a Medicare D plan it should automatically renew. I urge you to review your plan's "formulary" (list of covered drugs) to make certain your plan still carries your prescription. If it does, you are probably ok for the next year.

If you are eligible for Medicare and elected not to enroll in Medicare D in the past but your needs have changed for prescription coverage, you are free to take advantage of the open enrollment in November and December. Enroll in a Medicare D plan and have your prescriptions covered as early as the next January.

Just be advised that there will be a penalty assessed on your premium by CMS for every month you were eligible for the Medicare D program but elected not to participate.

MEDIGAP AND POLITICS DON'T MIX

"We are hearing disturbing stories from beneficiaries across the country about excessive premium increases for Medigap supplemental insurance policies,"

-Sens. Harry Reid (D-Nev.), Max Baucus (D-Mont) and John Kerry (D-Mass)

The quote above is taken from a letter from those senators to the Secretary of Health and Human Services as quoted in The Hill's article, "Dems Leaders Urge HHS to Crack Down on Medigap Rate Hikes" Now that the rest of the "evil" private health insurance companies have been thoroughly chastised by the liberal politicians, it appears that a new target has been chosen by the "vile" politicians.

As an insurance agent, I am dismayed over the recent round of increases to Medigap plans. In my opinion, people who reach age 65 have already paid too much to the American health care system.

Original Medicare has 4 parts, A, B, C and D. Parts A & B are the closest thing to what most of us know as Major Medical health insurance. Part A is typically provided with no cost to the insured. It pays for you hospital, some nursing home and hospice expenses.

Part B is optional. It charges a premium of around $ 100 a month. The actual amount of the premium depends on when you enrolled and the amount of income you had two years before. It pays for routine doctor office visits as well as your doctor's services while you are in the hospital.

Medicare has a payment schedule they use to reimburse medical providers. That schedule is often less than the provider's normal fee. Medicare then only reimburses 80% of the costs of that lower reimbursement fee.

It would be nice if a supplement for Medicare was not even necessary. Unfortunately, as long as Medicare refuses to pay a medical provider's full fee, something has to give. Either the government needs to mandate physician's work for less than their due or allow another option for people to pay for the full amount of their medical bills. Medigap allows people to trade their premium money for a promise that the portion of their medical bills that the federal government does not pay will be paid.

Medicare supplement insurance is not mandated. If someone wants it, they will pay the premium. If they do not want Medigap, they are not required to pay the premium. Medigap is an option, just like Medicare B.

If people do not accept the proposed rate increase, they have the freedom not to pay the increased premium. If they want the insurance but not the increased premium they are free to shop with one of the many other Medigap carriers who have not increased their rates.

The practice of medicine is big business. Gone are the days when doctors were paid with chickens and pies. Doctors must pay their own way through school, staff and equip their office and monitor the health of people in their community. Until the government is willing pay all of their expenses, politicians have no right to gripe their fees.

One of the reasons socialized medicine is working in other countries, is because physicians do not have the freedom to set their own fees. In those countries, medical providers are salaried employees of the government.

FACTS YOU MUST CONSIDER AT RETIREMENT

Many years ago I had a teacher who would remind me, "You can be replaced." Now that I am older, I understand. What was perceived a threat then, is now a clear insight into humanity. No one is indispensible.

Baby Boomers like to think that we know it all and cannot be replaced. I hate to be the one to burst the bubble of contentment but the generation that is coming behind us has some fairly sharp minds. They will be able to build on our foundation.

A couple of years ago the first of the Baby Boomers began retiring and drawing Medicare. Many have elected to retire voluntarily. Several were forced to retire so that businesses could scale back on payroll.

Medicare is a government sponsored health insurance plan available to all qualifying U.S. citizens. To qualify for Medicare, a person must be age 65, disabled for 24 months or have end stage renal disease. It also requires that at least one spouse works at least 10 years in Medicare covered employment.

Very few jobs do not qualify for Medicare. It is recommended that those who have been employed in religious jobs, education or with the railroad all of their life verify that there is not another program for them, just in case.

Administered by CMS (Centers for Medicare Services), Medicare is the largest health insurance program in the country. It provides services and coverage to over 40 million people. Below are a few things to consider about your health insurance when retiring at age 65 or older.

1. Medicare is Your Base Plan

At age 65, all individual and family major medical plans, and most group plans, step aside and allow Medicare to fund and process all hospital related claims and most doctor's visits. The good news is that your health insurance premiums should drop drastically when you enroll in Medicare.

Medicare Part A will cost you nothing if you paid into Medicare during your working years. Medicare Part B coverage is available with a nominal premium. Its premium is generally paid out of your Social Security check. However, you can pay it directly if you enroll in Medicare at age 65 but defer Social Security Retirement benefits until later in life.

2. Medicare Supplement aka Medigap

Private health insurance companies often do not provide traditional major medical plans for people over the age of 65. Those that do, only provide health insurance through group plans. They are often secondary to original Medicare. They supplement original Medicare.

Compared to what you were paying for health insurance at age 64, Medicare supplement plans are relatively inexpensive. Just be aware that premiums are not locked in. They rates are subject to change. They will increase as you get older.

There is a window of time when you are guaranteed a Medicare supplement policy. That window is open during your first 6 months on Medicare.

If you apply for a Medicare supplement plan when you are first eligible for Medicare, regardless of your existing health, you must be issued. After your guaranteed issue window closes, you are free to change companies or plans. All you need to do is submit a new application. Just be aware that it will be medically underwritten.

If you are being treated for a chronic condition, or serious medical issues are present in your family's medical history, I recommend that you obtain a Medicare supplement plan during your initial enrollment. If you wait until symptoms appear to apply, your application will be denied.

3. Medicare Part C aka Advantage

Several years ago, congress authorized a new Medicare program with the Deficit Reduction Act of 2005. The new system is known as Medicare Part C or Advantage insurance. Money that was earmarked to support original Medicare was diverted to private insurance companies to handle Medicare claims. Insurance companies already were staffed and trained to handle health claims. The theory was that private insurance companies could do just as well, if not better than government. The cost to the government to handle the medical claims of senior citizens would decrease.

What looks good in theory does not always work in practice. The 111th congress claimed that the Medicare Part C "Advantage" program did not result in lower costs for American taxpayers.

The controversial Patient's Protection and Affordable Care Act that President Obama signed into law on March 23, 2010 does not eliminate the Part C "Advantage" program. However, it does freeze the money that the federal government invests into the program at 2010 levels. In 2014, when the majority of the PPACA becomes affective, private health insurance companies will be required to pay for medical bills in 2014 with the same amount of money they received in 2010.

At that time, private insurance companies are expected to raise premiums and/or reduce benefits.

It is anticipated that majority of people who have an Advantage plan now, will elect to change back to original Medicare in the next 4 years.

Those who do, will need to get a Medicare Supplement to continue to have similar health insurance.

4. Medicare D Prescription Plan

Only 25% of people who are eligible for Medicare elect "Advantage." The majority of people stay with original Medicare. Around the time that "Advantage" plans were authorized another, more successful, plan was approved. It is called Medicare D. It is a cooperative plan funded by the federal government and premiums from seniors and administered by private health insurance companies.

Medicare D has been well received. It is better than the old system where Medicare did not pay anything towards prescription medications. Even with its improvements, the Medicare D program still has some draw-backs.

The largest one is called the "donut hole." The "donut hole" is a period of time when an insured must pay 100% of the costs associated with prescription drugs. It appears after one has paid $ 2830 [2011] in drug costs and disappears only after the amount paid for prescriptions exceeds $ 4550 [2011]. The "donut hole" limits are changed each year by CMS.

The PPACA has taken steps to close that hole completely by 2020. Until then the "donut hole" will continue to exist. It continues to attacks from those who complain about the high cost of prescription drugs.

The process of getting Medicare D is similar to "Advantage". There is an initial enrollment at the time you enroll in Medicare. If you do not enroll in Medicare D at that time, you are still able to join a Medicare D plan in the future. You must wait until the next annual enrollment period. Just be advised there is a penalty assessed for every month that you were eligible for Medicare D but elected not to participate.

MEDICARE AND YOUR RIGHTS

Each year, all Americans, age 65 or older, must make 2 decisions about their Medicare plans. They must decide to either keep their current plans with the changes that are being made or reposition themselves. They only have a 6 week period in which to make any changes. Once their enrollment window closes they must live with the choices they made until the next year.

Whether or not the politicians want to admit it, Medicare is a huge business. Thousands of companies and millions of jobs have an investment in the program. Medicare spends billions of dollars each year. Every stake holder wants his/her fair share.

Each year, people over the age of 65 are inundated with ads about Medicare D and Medicare Advantage plans. The Patients Protection and Affordable Care Act, aka PPACA, aka Obamacare has caused changes to both programs. Whether the changes are for the good or bad, you will have to decide for yourself in the future.

People who participated in Medicare D or Medicare Advantage last year cannot assume everything is as it was. They need to review their plans each year.

If the plan they have has not made any major changes they need to do nothing. If, however, their plans have either withdrawn from the program or made unacceptable changes, they must react. They must contact someone to help them make necessary changes.

If you find yourself having to make changes this year, remember your rights. Don't allow any insurance agent to bully you into changing or remaining with a plan that does not meet your needs.

Medicare beneficiaries have certain guaranteed rights and protections. These rights include: being treated with dignity and respect at all times, being protected from discrimination, getting

information about Medicare that is easy to understand and helps to make health care decisions, getting answers to questions about Medicare, making complaints about payment, services, or other problems, appealing decisions related to receipt of or payment for services or benefits, and having personal health information kept private.

Insurance agents are required to certify with CMS each year that they know your rights. We must demonstrate that we have reviewed the old rules and learned the new rules. We must prove that we understand Medicare's regulations before we are allowed to work with Medicare D or Advantage plans.

This certification is a federal requirement. It is in addition to any state insurance licensing requirements.

Before an insurance agent is allowed to discuss your Medicare C or D options, you must sign a "Scope of Appointment" form. That form will list what will be discussed during your conversation. If your insurance agent does not get your signature on the "Scope of Appointment" form, he/she is operating outside of the law. Red flags and warning flares should go off in your head.

SIGNS THAT YOU ARE ABOUT TO BE SCAMMED

How to know if your insurance consultant is on the up-and-up is very difficult. It is easy for a dishonest individual to misrepresent him/her self. It is even easier for scam artists to operate during times of confusion.

There is no question that the changes to health insurance in 2010 have caused a great deal of confusion. The confusion of the PPACA makes a good place for insurance scam artists to thrive.

Although the state Departments of Insurance and federal Department of Justice will prosecute those who are caught abusing health insurance laws, crooks are not always caught by the authorities. It is up to you, the consumer, to take steps to protect yourself.

Scam artists often target the elderly. If someone approaches you or your parents in these ways, be wary.

Unsolicited Phone Calls

It is illegal for any insurance agent to make "cold calls" for Medicare D or Medicare Advantage plans.

They are allowed to return phone messages that are left by a person on Medicare. They can also call a person if they were asked to by that person either in public, by email or U.S. post. They cannot call people unless they can prove that their call was expected.

That includes referrals. If you want Aunt Betty to speak with your insurance agent, you will have to persuade Aunt Betty to call him/her. The insurance agent cannot initiate the conversation.

If you or your parents receive an unsolicited call, a red flag of warning should go up.

Door-To-Door Marketing

Each year, some insurance agent picks a neighborhood and goes door to door looking to sell health insurance during the Medicare Annual Enrollment. Although this is a perfectly legal marketing technique for many types of insurance, CMS declared the marketing of Medicare D and MA plans, using the door-to-door method illegal several years ago.

If someone you or your parents are not expecting knocks on your door and starts talking about Medicare D or MA plans, red flags of warning should go up.

Unapproved Literature

Color printers make it easy to print up counterfeit marketing material. It is imperative to inspect every piece of literature that you are provided. Make certain it is legitimate.

Everything that is provided in print dealing with Medicare D or MA plans must be approved by the insurance company's legal departments. The Centers for Medicare and Medicaid Services, aka CMS have strict standards on what is acceptable advertising and what is not.

Every piece of literature your agent provides to you should have an approval code someplace on it. If you are unable to find that code, a red flag of warning should go up.

Certification

Each year, insurance agents electing to work with Medicare D or Medicare Advantage plans must certify with CMS. The certification makes certain that the agent has a thorough knowledge of the most current rules for dealing with people on Medicare. Certification training usually occurs a month or two before the Annual Enrollment.

If you or your parents need to speak with an agent during the Medicare Open Enrollment, ask him/her when his/her most recent Medicare certification occurred. If they say that they are exempt from certification, red flags of warning should arise.

Insurance agents are not required to carry their certifications with them but should be able to produce them if you ask.

Documentation

CMS requires insurance agents to document any conversations they have about Medicare D or Advantage. Before an agent is allowed to discuss details about the plans, unless it is a group

event, you are required to sign a “Scope of Appointment” form. That form details exactly what products will be discussed during your time together. An agent may discuss Medigap as an alternative to MA plans but may not discuss life insurance during the same appointment.

The insurance agent is required to keep your “Scope of Appointment” form in your file for 10 years. It must be produced at the request of Medicare if an audit is ever done.

If you or the agent wishes to discuss life insurance, a new appointment must be arranged. That appointment must be at least 24 hours in the future. This gives you time to “cool off.” It helps guarantee that you are not being bullied into doing something that you do not want to do.
If you or a parent meets with an agent to discuss Medicare D or Medicare Advantage and a signature on a “Scope of Appointment” form is not obtained, a red flag of warning should go up.

We can’t know every trick crooks will use but we can know some. When it comes to health insurance, knowledge is power. To protect yourself, know what to look for.

WHAT’S NOT COVERED DURING MEDICARE’S ANNUAL ENROLLMENT?

There is a misunderstanding regarding Medicare's Annual Enrollment. It needs to be cleared up.

The Medicare Annual Enrollment is for Medicare D and Medicare Advantage programs only. It allows people in those two programs to make changes to those plans only.

The Medicare Annual Enrollment does not apply to Medigap. These types of plans are also known as Medicare Supplement plans. They pay some or all the medical costs that traditional Medicare does not pay, except for prescription coverage.

Medigap plans are standardized from one insurance company to the next. You can tell which plan you have by the letter on your insurance card A-M. A plan F is the same whether it is with company ABC or company XYZ.

If you tell an insurance agent or medical provider which plan you have they will know exactly how much of the bill will be paid for by your insurance company. The only differences between companies for which you are paying premiums are the logo on your ID card, the customer service you get and the premium you pay.

Unless a person is within 3 calendar months of their birth month, if they elect to change from one Medigap plan to another, they are subject to the new insurance companies medical underwriting and pre-existing condition clauses.

There are a handful of special enrollment periods and company promotions where current health status is ignored but don't count on them.

For 2011, approximately 1% of companies offering Medicare Advantage, on a national level, withdrew from the program. Additionally, approximately 5% of Medicare Advantage plans

have made major changes to their benefits. That means that for 2011, roughly 94% of people with Medicare Advantage plans will not notice any changes except for premiums.

On the other hand, roughly 6% of people with Medicare Advantage plans will have to make a decision in the next 6 weeks or default to the traditional Medicare plan without any supplement.

While some areas of the nation will hardly notice any changes to their Medicare Advantage programs, other areas may see as high as 50% of those with Medicare Advantage participants affected.

The only way to know for certain whether or not you are affected is to read everything you get from your current Medicare Advantage plan.

Each year, Medicare Advantage companies mail you a letter describing any changes they were make. If you received a letter stating that your Medicare Advantage plan was withdrawing from the market you have two choices to make.

1) If you wish to remain in the Medicare Advantage program for another year, you will need to enroll for a different policy during the Annual Enrollment Period.

2) If you elect to return to traditional Medicare but want a Medigap plan to pay for things Medicare does not, keep that letter. Many companies will waive their medical underwriting for a short period of time if you send them a letter to prove that you were covered by Medicare Advantage but your company has completely withdrawn coverage from your area.

If your Medicare Advantage plan is discontinued, don't panic. Submit your application for Medigap as early in the Annual Enrollment as you can. That way you can get a final decision in time to make appropriate arrangements for your Medicare D, prescription drugs.

RETIRING? DON'T PANIC

Medical costs during retirement can eat up a great deal of money. I have no doubt that the
I read an article in Medical News Today that is scary. The article, "Retired People Still Need Hefty Savings to Cover Out-Of-Pocket Medical Costs, Despite Health Law," is incomplete and one sided.

The figures in the article are correct. The math has been double checked. I have no reason to suspect that the editors of Medical News Today have any reason to be sloppy with their facts. My problem is not with what they say but with what they do not say.

Medicare B will cover all but a nominal deductible and 20% of your medical bills. Most American's will pay about $ 100 a month for that insurance. That will leave you responsible for the extra. That amount plus the Medicare monthly premiums is what the article in question calculates you will need to save up for before retirement. They estimate that you will need $ 120,000 -$ 250,000 just to pay for medical care during retirement.

That is not entirely true!!!

While the medical costs you become responsible for during retirement may very well be $ 120,000 -$ 250,000, you may not have to pay it yourself. Medigap will pay those excessive medical bills for a fraction of the costs of what the "experts" predict you will need.

Working with the private insurance industry and not against them, the federal government, through the Centers for Medicare and Medicaid Services (CMS) has standardized several Medigap insurance policies.

I feel the need to point out that I do not dispute Medical News Today's math. I just do not want people my age and older scared into thinking that retirement is not a viable option. It still is obtainable. As long as Medicare does not experience a drastic change all of us can look forward to an affordable retirement.

MEDICARE SELECT

Some insurance companies offer an even deeper discount for Medicare Supplement policies if the insured agrees to use a participating hospital in the event they need a future non-emergency hospitalization. These plans are called Medicare Select.

The premiums are lower than normal but they have limitations.

Select plans still provide coverage for Medicare approved medical treatment under Part B and emergency hospitalizations.

The difference is with non-emergency hospital care. When an insured has time to plan for surgery the insured will have to use a participating hospital to receive full benefits. Since an insured has voluntarily given up some benefits, Medicare Select plans tend to be less expensive.

Medicare Select is not right for everyone. If you live in one of the towns that have a participating hospital it may be right for you. If you don't have easy access to a Medicare Select hospital, my advice is to stay away from that type of policy.

CONSIDERATIONS FOR MEDIGAP

There are a couple additional considerations when deciding which Medigap plan best meets your needs.

Foreign Travel Emergency

All Medigap plans, other than plans A, B, K and L, have this coverage. Traditional Medicare only covers medical bills incurred outside of the United States.

The Foreign Travel Emergency benefit covers most medical bills while you are traveling. At least it will allow you to get some medical help while you are over-seas.

This portion of your policy will increase your health insurance up to $ 50,000 while you are out of the United States. If you are traveling and become ill or have an accident, the Foreign Travel Emergency benefit will make payments based on the Medicare payment schedule that is used in the United States.

It is less user friendly than regular Medicare. It is your responsibility to pay the medical provider in the area you are visiting. Insist on and save any receipts for medical treatment. When you return home you will file a claim form, copies of the medical bills, receipts and the itinerary from your trip with your Medicare supplement insurance company.

Your Medigap insurance company will then reimburse you 80% of the Medicare approved amounts for the medical procedures you had while traveling. Keep in mind that there is a $ 250 deductible that applies to this benefit.

This benefit is not unlimited. Medigap has a $ 50,000 lifetime limit for each insured. If you have a heart attack while traveling and the bill comes to $ 100,000, Medigap will only reimburse you up to $ 50,000. You will have to pay the rest out of your savings.

Also, keep in mind that this benefit will only reimburse for Medicare approved m medical treatment of an urgent or emergency situation. It will not pay for elective or pre--meditated surgery over-seas. This benefit will only reimburse for Medicare approved medical treatment of an urgent or emergency situation. It will not pay for elective or pre--meditated surgery over-seas.

For more information about the e emergency travel benefit, read your Medigap policy or call your insurance company's customer service department.

Part B Excess Payment

Medical providers who accept Medicare Assignment are limited on their fees. Medicare has a schedule of the amounts they will pay for each medical procedure. Medicare will pay 80% of what is on that schedule to your doctor or hospital. You, the patient, are required to pay anything left over.

All doctors who accept Medicare e Assignment have agreed to limit their fees to M Medicare's schedule of payments or less.

To Medicare, it makes little to no o difference what your doctor charges. That program is only going to pay 80% of Medicare's schedule of fees. You the patient are responsible for the balance. That is why you purchased the Medigap plan in the first place.

If your doctor does not accept M Medicare Assignment, he/she is free to charge up to 115% of what Medicare says is a fair price. Only 3 of the approved plans, F, F-HD & G will pay anything above what is stated in the Medic care schedule of fees.

If you elect one of these plans and visit a medical provider that accepts Medicare Assignment, your entire bill will be taken care of through either Medicare or Medigap. As long as your doctor accepts Medicare Assignment, you should not have any other medical bills, other than a deductible, with plans F, F-HD and G.

If you elect a plan other than F, F F-HD or G and your doctor charges 115% of the Medicare approved fee for a procedure you u could be stuck with an extra bill. Medicare would pay 80% of the approved amount. Medigap would pay the additional 20% of the Medicare approved amount and you would get a bill for services from your doctor for the additional 15%.

Premiums should not be the only thing you consider when you purchase a Medigap. You also need to consider your future travel habits and if your doctor accepts Medicare's schedule of fees or wants more.

CONSIDER MEDICARE SUPPLEMENTS WHEN YOU RETIRE

Today I processed the paper work for a client who has taken a contract overseas. He just turned 65 earlier this year and while Medicare does not provide coverage for him outside of the U.S., he considered the potential problems he could run in to in the future.

Many people who retire at the same time they are eligible for Medicare are not taking prescription drugs. If they are, their drugs are often one of the $ 4 generic drugs available through many pharmacies today. They do not see any good reason why they should spend money to join a program from which they do not benefit.

What they see is that there is a 6 week open enrollment each year in which they are permitted to join any Medicare D plan they want, regardless of their health.

There are 2 things that they often fail to consider.

Timing

An individual enrolling in Medicare for the first time also has a right to enroll in a Medigap and Medicare D plan during their 7 month initial enrollment. During that time, health history is not allowed to be considered. If you apply for either a Medigap or Medicare D plan, the insurance company you applied to is required to approve your application for health insurance. It makes no difference if you are taking 0 or 100 prescription medications each day.

Unfortunately, if you wait until after your initial enrollment period some bad things could happen.

Medigap

After your open enrollment, insurance companies are allowed to use medical underwriting. As long as your health status meets the insurance company's health requirements, you will not have any problems obtaining or switching your Medigap plan.

Under current law, your options are very limited after you have been diagnosed with something.

Medicare D

Did you know that Medicare D is purely optional? There is, unfortunately, a penalty for people who do not elect the Medicare D plan when they are first eligible for Medicare and enroll in the program during an open enrollment at a later date.

Medicare D premiums are typically very inexpensive. People, who find the premium a financial hardship, may be eligible for additional assistance.

Penalty

Under current law the penalty is 1% of the average national Medicare D premium for each month that you were eligible for Medicare D but elected not to participate.

The Medicare D penalty is not just assessed for one year. That penalty will remain for your entire life.

Assume you were born in September and your initial Medicare enrollment expired in December.

Also assume that you elected not to participate in a Medicare D program at this time.

You will not be eligible to participate in Medicare D until the next calendar year. That will be a minimum 12% premium penalty. If you elect Medicare D for the following year, you will pay both the monthly premium and the penalty.

Now, let's assume that you do not need an abundance of prescription medications until you are 75 years of age and delay enrolling in Medicare D until then. That will result in a 120% percent penalty plus the base premium of the plan you enroll in at that time.

When you look only at the premiums, Medigap and Medicare D plans may appear to be expensive. As you make your retirement planning decisions, however, consider the big picture. How much could it potentially cost you in the future?

MEDIGAP FOR THE DISABLED

I was doing some routine research when the following quote in n the Washington Post caught my eye. In "Medigap supplemental coverage can be too pricey for younger Medicare beneficiaries," Susan Jaffe documents the problem Joe Hobson of Virginia, age 23, is having with Medicare and Medigap.

"Because there is no annual cap on Medicare out-of-pocket costs, there's no limit to how much beneficiaries might be required to pay if they get very sick or have a very expensive medical condition. "It makes sense to buy Medigap insurance to mitigate that possibility,"

The article quotes Bonnie Burns, a policy specialist with California Health Advocates. CHA is a nonprofit organization. It is a member of a federal group that updates Medigap r rules when Congress makes changes.

I know insurance regulations in Texas; not Virginia. Regardless of what state in which you live, proper planning is required. You need to know what the rules are in your state any time you are forced to rely on Medicare as your primary health insurance.

Medicare is the largest health insurance company in the nation. Since it is regulated, managed and funded by the federal government, Medicare is free to do anything it wishes. Major changes have to go through both houses of congress and a president. Relatively minor changes to rules can be made by the Secretary of Health and Human Services.

The only way an individual under the age of 65 can be a Medicare recipient is if they have received Social Security Disability Insurance for 24 months or are suffering from m End Stage Renal Disease.

Private health insurance plans generally have a maximum Out-Of-Pocket or OOPP. Once an insured has paid that figure plus their deductible the insurance company will pay 100% of medical bills for the rest of the year or policy term. Medicare does not have that consumer protection benefit.

At first glance the fact that Medicare has no limits sounds wonderful. What often is not made clear is that there is no OOP with Medicare. Medicare only pays 80% of approved medical bills. Individuals are personally responsible for the other 20%. If a Medicare patient has medical bills of $ 500,000, Medicare will pay $ 400,000 but the individual is on the hook for $100,000.

A Medigap plan assumes the insured's liability. It pays most, or all, of the medical bills the individual is left with by Medicare.

HOW CHEESEBURGERS ARE SIMILAR TO MEDIGAP

Wimpy has nothing on me. There are 7 places, within 2 miles of my house, where I can purchase one of those heavenly disks of ground beef. I go to one when I am not able to get a hamburger from my favorite source; the grill in my back yard.

You are probably asking why this confession is being made in a book about the insurance needs of Baby Boomers and their parents. Actually, there is a logical reason. Medicare Supplement plans are very similar to hamburgers. You can get them from many places. There are reasons why you choose one place over another.

A hamburger is only the ground up flesh of a cow. It is nothing special. In every restaurant they will give me the exact same thing.

Medigap is exactly the same. It does not differ significantly from one insurance company to the next. The Center for Medicare & Medicaid Services has standardized Medicare Supplement insurance. The products are the same from company to company. If that's true, what's the difference between company A and company B?

Price

Although a hamburger from a fast food joint is the same as a hamburger in a fancy restaurant, there is a big difference in price. If I have a lot of money in my wallet and I want to impress my wife, I might be tempted to pay the fancy restaurant's price. If I do not feel the need to impress anyone, I have been known to use a drive through.

Medigap is the same. Some people are willing to pay higher premiums in order to impress others. They think it is more prestigious to be insured with ABC insurance company rather than XYZ, even though their policies are identical.

Others do not see the need to impress with their insurance choices. As long as their claims are paid, they are happy to pay the lowest premium available.

When you are shopping for Medicare Supplement, price is a major consideration. Just be aware that it is not the only one.

Experience

If I take a client to the drive through, we will get the same meal as if we had gone to the country club across the street. The difference between them is not in the meal but the experience. Rather than having a seat belt across our laps we could sit down to have our meal brought to us and eat with a linen napkin on our laps.

If there is any problem with my dining experience in the country club, it will be corrected in a jiffy. I have a right to expect the staff to make things right.

If, however, there is a problem with my order in a drive through, things are not as easily corrected. I have to get out of the car and walk into the restaurant. After that I have to get the

manger's attention and complain that the teenager at the window was not paying attention and messed up my order. I feel like a tattle-tale. Only after I do that will the manager ask another teenager to slap a hamburger patty between 2 slices of bread, put it in a paper wrapper. The manager will then thrust it at me with the words, "I'm sorry you were inconvenienced, please come back."

Although in both places I am able to satisfy my craving for a hamburger, the experience is different. The same is true when you choose an insurance company.

Ideally, there will never be a problem with your Medigap claim. Realistically, however, insurance companies are made up of humans. Humans make mistakes. Since humans are involved, you cannot afford to assume that there will never be a mistake.

When you are shopping for Medigap, obviously, premium rates will be a consideration. However, you can't afford to purchase insurance based solely on price. You will need to also look at the experiences others have had when working with those insurance companies to solve problems. You will need to balance price vs. experience.

Toppings

I prefer my hamburgers with only cheese. Others prefer to top their burgers with other condiments. If I am at a place that insists on giving me all the traditional burger toppings, I ask them to put all of it on the side. My philosophy is, "If I wanted a salad, I would order a salad. If I want a hamburger I'll order a hamburger."

You can't always have Medigap "your way." Insurance companies are not allowed to build your Medicare Supplement to your specifications. CMS has standardized Medigap plans. If you want a Medigap, you must choose from the menu that CMS has prepared.

There are several plans from which you may choose. If you want it "plain" you will probably look at plan A. If you want it "all the way" you will probably want to look at Plan F. If you are like me, and like a little topping but not too much, you might like one of the newest plans M or N.

The only option you will find offered by every insurance company will be Plan A. If the insurance company you have chosen does not offer the plan you want, you will have to decide between the insurance company you have chosen and the Medigap plan that best meets your needs. It is not always the easiest decision to make but it may be required.

If you are looking for your Medigap options but want to look over the "menu" first, read the CMS publication "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"

REVIEW YOUR HEALTH INSURANCE AT 65 EVEN IF YOU ARE NOT RETIRING

More people than ever before are electing to postpone Social Security and remain in the work force past age 65. We Baby Boomers and our parents remain hearty, even into what is traditionally called the “Senior Years”

The Department of Labor tells us that there are about 52 % more people over age 65 in the work force than there was just 10 years ago.

That number could easily be misinterpreted. After all, there are millions more in the Baby Boom generation than in our grandparent’s generation. It is only logical that there will be more of us who elect to postpone Social Security retirement benefits.

Still, even if you have elected to wait to take your Social Security payments, unless your employer is providing group health insurance to you, your only option for health insurance will be through the Medicare system.

According to a recent Kaiser Family Foundation study, the number of large employers who continue to provide health insurance to employees past age 65 has decreased in recent years from 40% to 28%.

If your plans are to postpone Social Security retirement and continue to work past age 65 I encourage you to review your health insurance with a magnifying glass to make certain there are no changes to your coverage.

Many health insurance plans cease to cover you in the year in which you turn 65.

People who will lose their major medical health insurance at age 65 will need to obtain a Medigap plan during their 6 month Open Enrollment if they have a pre-existing condition. I urge individuals with genetic disorders in their family to look into Medigap at that time.

Medicare has no limit on what it will pay. It will only pay 80 % of medical bills. If a cancer, heart attack, stroke or other genetic disease costs $ 100,000 to treat, Medicare will pay $ 80,000.

You will have to raid your retirement savings for the other $ 20,000. Your only other option is to allow Medigap to pay the portion of the medical bills that Medicare does not.

If your employer continues to provide you with health insurance, you need to verify if your health insurance is primary or secondary to Medicare. In either case, your medical bills should be taken care of.

The difference is in the choices available. If your group plan is primary you will still be able to use the doctors you were using before you turned 65. If however, Medicare is primary, you may be more limited. If the doctors you were using will accept the lower fees that Medicare pays, you will have no problems. If, however, your doctor does not accept Medicare assignment, you may have to search for another doctor. You may have to do more planning for continuity of medical care than you assumed.

Review your plans. Find any changes that you need to make. If there are none, all you have done is spent a few minutes learning how to use your health insurance more efficiently. If, however, there are changes that are required, it is much easier for you to make those changes while you are still in good health. If you wait until something serious happens you could be in for a surprise.

3 BEES FOR RETIREMENT INSURANCE PLANNING

The PPACA allows people to disenroll from their Medicare Advantage plan and return to original Medicare. That does not mean that every person who disenrolls from Medicare Advantage is guaranteed a new Medigap.

If a person with Medicare Advantage is used to having an out-of-pocket spending limit, they will notice a problem with original Medicare if they do not obtain a Medigap plan at the same time they disenroll.

The best way to deal with problems is to avoid them in the first place. When you are shopping for Medigap, learn from our insect friends.

Bee Informed

The PPACA offers an opportunity for people to disenroll from Medicare Advantage and return to original Medicare. The politicians make a big deal out of this new provision. What the politicians are not saying is that those people who elect to disenroll are not guaranteed a private Medicare Supplement insurance policy.

There are only 10 times when you will be guaranteed approval for a Medicare Supplement. If you cannot qualify with one of these guaranteed issue exceptions, you must be healthy enough to pass medical underwriting.

1. You're in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

2. You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. *Note: In this situation, you may have additional rights under state law.*

3. You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.

4. You're in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

5. You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. *Note: In this situation, you may have additional rights under state law.*

6. You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.

7. (Trial Right) You joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.

8. (Trial Right) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you have been in the plan less than a year, and you want to switch back.

9. Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.

10. You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.

Medicare is run by the federal government. It follows rules made by congress and the Department of Health and Human Services through its subsidiary, the Center for Medicare and Medicaid Services, aka CMS.

Medicare Supplement plans are completely different. They are provided by private insurance companies. They are subject state regulations rather than federal mandates. Although CMS does say what plans may be offered and who can qualify for guaranteed issue, they are subject to their insurance company's underwriting criteria.

Bee Pro-Active

I realize that purists will say that "Pro-Active" was not a real word when we were in school. Today it is a proper noun for an anti-acne skin cream.

Between the times I was in high school and today, "Pro-Active" became a buzz word in corporate conference rooms. You would not have found the word in any proper English class of the 1970s but it was everywhere in business reports by the 1980s.

The idea of being "pro-active" is to take steps to prevent a problem from even occurring. If a problem was unavoidable, being "pro-active" means that steps are taken to minimize the damage that will be caused.

The lesson Hurricane Ike taught can be applied to Medigap as well. Everyone knew that a major hurricane was coming. We just did not know how bad it would be.

We know that a hurricane of high medical expenses is heading straight for Baby Boomers as we retire. We just don't know who is going to get hit the hardest. Medicare, as it is today, will pay approximately 80 % of those bills. However, you will have to find a way to pay the 20 % that it does not pay.

Your options are;

1. Don't seek medical care
2. Pay the doctor out of your pocket
3. Deal with bill collectors
4. Obtain a Medicare Supplement insurance policy
5. Qualify for Medicaid in your state

If you elect any option, other than # 3, "Deal with bill collectors," life will be a whole lot easier if you make plans now. Make them while you are healthy. Don't wait until you are in the hospital.

The symptoms of a heart attack are bad enough. You do not need the added stress of wondering how you are going to pay for a trip to the Emergency Room.

Bee Patient

My experience has been that most insurance problems are caused by impatience. People want answers to their questions, they want them immediately and they want answers that favor them.

That may work if their question is, "What does 2 + 2 add up to?" When you have 2 apples and add 2 more apples you will always have 4 apples.

When it comes to insurance; that is not always the case. Insurance issues are more complicated and take time to find a solution. Unless you do everything perfect, it can be like someone replaced an apple with an orange. Instead of 4 apples you end up with fruit salad.

Each state has different regulations. It will take time for you, your agent and your insurance company to do the arithmetic.

Many policies are issued within 10 business days. Some take longer. When I am asked how long it will take to get a final answer I tell everyone that it can take as long as 8 weeks. That way, if a client gets a policy within 2 weeks they are pleasantly surprised. If it takes longer, they are not disappointed.

After you have submitted an application, be patient. Underwriters see anxiousness as a red flag. It has been my experience that when an underwriter senses anxiousness or impatience on the part of the applicant they tend to slow down rather than hurry up.

They want to know why the applicant feels that an exception applies. Their job is to prevent insurance fraud. If they approve too many costly policies, they could find themselves without a job.

No underwriter is going to allow him/her self to be rushed into approving a policy. When it comes to insurance, the proverb we learned when we were kids is true. "Good things come to those who wait."

INSURANCE ESSENTIALS DURING RETIREMENT

There are many private health insurance plans available. There are 3 that are essential when you retire. Those are,

1. Medicare Supplement Insurance (i.e. Medigap)
2. Medicare D
3. Long Term Care Insurance

If you have money for premiums left over after you have obtained those plans, go ahead and look at things like life insurance but these 3 plans should have a higher priority. In this book I only discuss Medicare supplement insurance. Read the other books in the series to learn about Medicare D and Long Term Care insurance.

The first two supplement what Medicare does not pay. Your enrollment in Medicare is a prerequisite. Unless you are receiving Medicare Disability benefits, there is really nothing you can do until you are 65.

The third insurance is essential to any person who enters retirement with $ 35,000 in savings or more. It protects your nest egg from the Medicaid laws.

The nice thing about Long Term Care insurance is that you do not have to wait until you are age In fact, if you are 55 years of age or younger, there is a very good chance that you can pay all your premiums during your working years and have a paid-up policy during retirement even though you are no longer paying premiums.

SECTION II - FAQ

In school, I understood things quickly. I would get frustrated with the kids who took longer and had to ask questions about stuff that was perfectly obvious to me. After years of sitting in meetings, I have gained a little more patience. Now that I am a little more mature, I understand that each person's brain works a little differently. Something that is easily understood by one person can be complex to another.

That realization came to me when I was studying for my CLU designation. I was stymied by the concept of "estoppel." For the first time in my academic life, I was unable to figure something out from a text book. I had to ask questions. It peeved me when people would say, "Oh, that's easy!" It wasn't easy to me.

Today, I understand estoppel. It means that an insurance company cannot pick and choose who they will enforce a policy provision on.

I also learned a valuable lesson. People learn differently. What may be simple for one person may be hard for another.

FAQ stands for Frequently Asked Questions. Below you are about to find some questions that I get asked on a regular basis about Medigap. Hopefully, you can benefit from the answers I have given other people.

HOW MUCH MONEY DO I NEED FOR MEDICAL BILLS DURING RETIREMENT?

Early in my career I learned that answering that question is dangerous. Everyone's needs are different. If I answer that question, I open myself up for a confused client and future problems.

If I over-estimate, I run the risk of having a client over-insured. That results in a client not having enough discretionary money to do the things they want to do in this life.

If I under-estimate, I run the risk of a client not having enough insurance to pay for care when they really need it. That results in a client having a huge bill hanging over them for years.

The best I can do is share what could happen in the future and the risks of doing nothing. Once I have done that, I need to shut up and let the customer decide for him/herself what is needed.

An article written by David Pitt of the Associated Press entitled, "Most are clueless on retirement's health care costs" was reprinted in the Philadelphia Inquirer and in the blogosphere.

There is no doubt, since it came from the Associated Press, that many other local newspapers published it as well. It reads as follows.

"When it comes to planning for health-care costs in retirement, most Americans have little clue."

A survey by Sun Life Financial found that 92 percent of workers said they don't know how much their health care will cost in retirement or vastly underestimated the amount.

Only 8 percent were in the correct range, estimating costs of $200,000 or more.

In fact, a 65-year-old couple retiring this year will need $230,000, on average, to cover medical expenses in retirement, according to a separate Fidelity Investments study released in March [2011]. That doesn't include most dental services, long-term care or nursing-home expenses."

I have no reason to doubt the numbers that are expressed in this article. I am certain that retirees will accumulate medical bills in excess of $ 200,000 if they live the additional 14 years the life expectancy tables indicate.

In a nation where the average person retires with only $ 69,000, I don't want retirees to think there is no hope. Many of us are in the same boat. With proper planning, that $ 230,000 lifetime medical expense can be trimmed to less than $ 30,000. That is still a lot of money but it is much more realistic.

Medicare will pay, roughly 80% of medical bills... Medigap and Medicare D will pay everything that Medicare does not, except for medication during the "Donut Hole." All that is required is that you pay your Medicare, Medigap and Medicare D premiums when you retire.

Medicare A

Medicare Part A will absorb all of your hospital fees after you pay your deductible. There is generally no cost for that coverage. You paid your premiums in the form of Medicare taxes.

This is often the most confusing part of Medicare when you get your bills. Many people think that Medicare will pay everything. That is not the case. Medicare Part A only pays 100% of medical bills that are associated with the hospital. Services that are provided by doctors and surgeons are covered under Medicare B while you are in the hospital. They are only paid for at the 80% level by Medicare.

Medicare B

People are under the mistaken idea that Medicare will pay all charges while they are in the hospital. Medicare A will pay for charges associated with their hospital stay but not their doctor's fees. If they want doctor's fees to be paid by Medicare, they will need to enroll in Medicare Part B.

Medicare Part B is optional insurance coverage. For most of us the premium is relatively affordable. If you do not enroll in Medicare Part B when you are first eligible, you will pay a penalty if you enroll in Part B at a later time.

Medicare D

Neither Medicare A nor B will pay for prescription medications. To cover prescriptions you will need to enroll in Medicare Part D. It is an optional program that is available to anyone on Medicare. You may only enroll in it during an open enrollment period.

There is an initial open enrollment available to you around the time you first are eligible for Medicare. If you elect not to enroll in Medicare D when you are first eligible, there is a 6 week open enrollment during the last quarter of the year. You may enroll in Medicare D at that time. Just be prepared to pay a penalty along with the premium if you enroll in Medicare Part D if you elected not to enroll in Medicare D when you were first eligible.

The penalty for late enrollment in Medicare D is 1 % of the national average premium for Medicare D plans for every month that you were entitled to participate in Medicare D but elected not to. Many people are confused over this penalty. It does not go away. You will have the premium penalty for the rest of your life.

Medigap

If your medical bills are $ 100,000 you are still responsible to pay Medicare's deductible plus any coinsurance that is required.

In addition to the optional Medicare Parts B and D, you will also want to purchase a Medigap plan to pay for the portion of medical bills that Medicare does not.

You have a right to obtain a Medigap policy during the first 6 months of your enrollment in Medicare. During that time, your health history cannot be considered. If you do not get a Medigap at that time, you must medically qualify for the insurance.

HOW DOES MEDICARE WORK IF YOU ARE HIT BY ANOTHER DRIVER?

Below are two scenarios taken directly from Medicare's book, "Medicare and Other Health Benefits: Your Guide to Who Pays First."

Joan

Scenario (1) assumes that Joan, a Medicare enrollee, is injured in an accident caused by someone else.

Joan is driving her car when someone in another car hits her. Joan has to go to the hospital. The hospital tries to bill the other driver's liability insurer. The insurance company disputes who was at fault. It won't pay the claim right away. The hospital bills Medicare. Medicare makes a conditional payment to the hospital for health care services that Joan received. Later, when a settlement is reached with the liability insurer, Joan must make sure that Medicare gets its money back for the conditional payment.

Nancy

Scenario (2) assumes that Nancy, a Medicare enrollee, is injured in an accident caused by someone else.

Nancy is 69 years old. She's a passenger in her granddaughter's car, and they have an accident.

Nancy's granddaughter has Personal Injury Protection/Medical Payments (Med Pay) coverage as part of her automobile insurance. [In some states this is called "no-fault" insurance. If you are not certain if you have it, ask the insurance professional who helps you with your auto insurance.]

While at the hospital emergency room, Nancy is asked about available insurance coverage related to the accident. Nancy tells the hospital that her granddaughter has Med Pay coverage. Because this insurance pays regardless of fault, it is considered no-fault insurance. The hospital bills the no-fault insurance for the emergency room services, and only bills Medicare if any Medicare-covered services aren't paid for by the liability insurance.

In both scenarios, the person who is at fault in the accident is liable for the medical bill. Their auto insurance will take care of the bills up to the limits on their insurance policy. After that, the driver will personally have to pay Joan's and Nancy's medical bills.

There are two insurance lessons to take from these scenarios.

First, if you drive an automobile, regardless of your age, don't skimp on liability insurance. Medicare will not allow one of their enrollees to get in trouble for something that they can control. If there is a delay from the insurance company, Medicare will go ahead and pay their share of medical bills for their enrollee.

After they pay their share, they will ask the driver and/or his insurance company to reimburse them for what they paid. The fancy term for this is "subrogation."

If the at fault driver does not have enough liability insurance to pay everything that Medicare pays, he can expect Medicare to come after him.

Second, if you are enrolled in Medicare, don't avoid Medigap. Medicare enrollees need to remember that even if Medicare helps out on the medical bills, that help will be subject to Medicare's payment rules. They will subtract the Medicare deductible from the medical bills and only pay 80 % of the balance.

If you do not have a Medicare Supplement, it will be up to you to secure an attorney to get the other 20 % plus deductible from the at fault driver. Often, your doctor will not wait for the courts. He wants his money. If he does not get it in a timely fashion, he will send your account to collections. You will have no choice but to pay him first and then if you can get your money from the other driver.

If you have a Medicare Supplement plan, you have nothing to worry about. It will pay what Medicare does not. If the insurance company feels they have a case, they can spend their money on attorney fees to pursue "subrogation" against the at fault driver.

IS IT TOO LATE TO GET MEDICARE SUPPLEMENT INSURANCE?

Most people enroll in Medicare when they turn 65. Their 6 month Open Enrollment begins on the first of the month in which they turn 65.

Even if a person is diagnosed with a major disease on his 65th birthday, a Medigap provider must approve their application for Medicare Supplement insurance. If it is completed within that 6 month's Initial Enrollment Period, issue is guaranteed.

The underwriting rules for Medicare Supplement insurance are different than for the health insurance you had during your career. Something that was a pre-existing condition before you retired may not be considered a pre-existing condition for Medigap.

For example, a person who is dependent on insulin injections is an automatic decline for major medical insurance prior to age 65. After age 65, that is no longer the case. As long as he takes less than a stated number of units of insulin each day, he may still be able to get a medically underwritten Medicare Supplement. Still, it is better for him to get Medigap during his Guaranteed Enrollment Period.

Many people see a dramatic decrease in their health insurance costs at age 65. In many cases the cost for health insurance will decrease by several hundreds of dollars. Often, people are reluctant to use a fraction of that decrease to obtain a Medicare Supplement during their Guaranteed Enrollment.

With all the publicity and promises that Medicare will take good care of them, they do not realize that Medicare has holes. Medigap plugs those holes.

HOW TO JUSTIFY THE COST OF MEDIGAP?

Medicare has no Out of Pocket cap. There is no Stop-Loss to protect you against high medical bills like there was in your previous health insurance.

Prior to your retirement, if you had a $ 100,000 medical bill, your health insurance would require you to pay your deductible first. After you paid your deductible, you and the insurance company would share the bills. This is called the "co-insurance" phase. They would have paid a percentage of the bills, let's say 80%. You would have paid the other 20%.

That is common to both private health insurance and Medicare. This is where they differ. After you have paid a stated Out-of-Pocket amount in co-insurance, say $ 2000, the private health insurance plan would pay 100% of the rest of your medical bills for the year. The maximum you would be responsible to pay is $ 2000 plus deductible.

If you never get sick or have an accident, you are only out the premiums with Medigap. If however, you are ever involved in an accident or develop a chronic disease requiring expensive medical treatment, you are in fine shape.

WHY DO I NEED A MEDIGAP?

Only you can answer that question. Just be aware that without a Medicare Supplement you are leaving yourself open to an uncapped medical bill.

There is no question that Medicare Supplements can get pricey. The alternative is to leave a huge hole in your insurance portfolio. Medigap allows you to get quality medical care in the future when you need it.

You have two choices. You can choose to pay premiums for a Medigap plan in addition to what you are paying for Medicare. Your other option is to pay doctors and hospitals out of your savings for that Medicare will not pay.

In a Question and Answer column by John Crudele of the New York Post he provides anecdotal evidence of why a Medicare Supplement plan can be necessary.

In his article, "Dr.'s Script on Medicare Billing Rules," Mr. Crudele points out, "The amount that can be billed to the patient is the difference between what Medicare pays and what Medicare says the medical procedure should cost. It isn't the difference between what Medicare pays and what the doctor would like to charge."

He does not point out that there is no cap on the amount of charges for which you can find yourself responsible. Most private health insurance plans have limits on the amount the insured must pay before the insurance company will pay 100 % of future medical bills. That is not the case with Medicare.

Medicare Part B has no Out of Pocket Maximum. You are responsible for 20 % of all medical charges that Medicare pays after you have paid your deductible.

In a year with very high medical bills, say $ 100,000, Medicare would pay approximately $ 80,000. Without a Medigap plan to absorb your costs, you would have to pay $ 20,000 out of your pocket.

CAN MY MEDIGAP BE CANCELED?

I was asked if a Medicare Supplement plan could be canceled just because someone gets sick or injured. It appears this client, along with thousands of others, were scared by the horror stories the politicians used in 2009 about people having their health insurance.

Medigap plans are "guaranteed renewable." As long as the insured continues to pay premiums, the plan cannot be canceled once it has been approved. Since that is a federal and not a state mandate, you would think that the politicians would know better.

If you need any further confirmation of this, check out the official publication of CMS. It says, "Any standardized Medigap policy is guaranteed renewable even if you have health problems.

This means the insurance company can't cancel your Medigap policy as long as you pay the premium."

Medigap plans may or may not be conditioned upon your health when you apply for them. They are not always guaranteed. Once you have one, keep it current until you get its replacement. If you cancel an old policy before a new one is approved and you are declined, you may not be able to get the old one reinstated.

Unlike Medicare Advantage plans, you are not allowed to switch from one plan or company to another every year.

You are free to chase the lowest premiums available between insurance companies but once you get ill, you are pretty much locked into the insurance company you have. If they raise rates on you, your only options are to change to a lower priced plan, with fewer benefits, or drop your Medigap plan completely. If you do that, you must be willing to pay the medical bills that Medicare does not out of your pocket.

If you are lucky you will become eligible for a Medigap Special Enrollment Period. The most common is your initial Medicare Open Enrollment Period. During that time you can get a Medigap plan regardless of your health. It is the 7 months surrounding your initial enrollment in Medicare. For many people that will be 3 months before and after the month of your 65th birthday and the month of your birth.

There are other Special Enrollment Periods granted by CMS. Below are the 10 Special Enrollment periods as defined in the CMS publication, "Choosing a Medigap." My advice is, "Don't plan on a future Special Enrollment Period. If you are going to get a Medigap plan, do it during your initial Open Enrollment Period."

1. You're in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

2. You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. *Note: In this situation, you may have additional rights under state law.*

3. You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.

4. You're in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

5. You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. *Note: In this situation, you may have additional rights under state law.*

6. You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.

7. (Trial Right) You joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.

8. (Trial Right) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you have been in the plan less than a year, and you want to switch back.

9. Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.

10. You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.

WHAT DO I GET FOR THE EXTRA PREMIUM WITH A MEDIGAP PLUS MEDICARE D?

I was asked this question last year by a client in an email. Here is my response.

"I reviewed the letter you sent and here is what I learned.

1. The letter confirmed what I suspected all along. Your Medicare Advantage plan was an HMO. It would be again if you elected to renew with XYZ's new plan. In other words, you would have the same complaint you have now. You will only be allowed to use their approved lists of doctors and hospitals. If you and your wife elect to re-up with XYZ make certain you read your policy when you get it so that you will know the limitations and exclusions.

2. This letter is not a withdrawal letter and may or may not be suitable for non-medical underwriting for Plan F. In it, XYZ is not saying they are leaving the area or Advantage program. They are just saying they have discontinued the plan you had and are replacing it with a different plan.

3. The new plan could potentially leave you and/or your wife with up to $ 2800 in miscellaneous medical bills in 2011. That is potentially, $ 5600 if you use the plan as it is intended. The Medigap plans I sent you would leave a maximum out of pocket for each of you of the Part B deductible ($162) and then $ 20 for every visit to your doctor ($50 if you go to the ER.) That is a potential maximum out of pocket of $ 324 for the two of you plus $ 20 per doctor visit. That means you would have to make over 263 doctor office visits in 2011 just to break even.

You asked what the extra premium buys you. Read # 3 again. It should answer your question."

ARE THERE "NETWORKS" WITH MEDIGAP PLANS?

It all depends on whether you have a true Medicare supplement insurance plan, a Medicare Advantage plan or a Medicare Select plan.

Medicare Advantage (MA)

MA plans replace Medicare parts A & B. They are required to provide the same services as Medicare.

Original Medicare requires medical providers to send their bills directly to Medicare. The federal government then takes care of the claim.

Medicare Advantage plans are different. The federal government pays the insurance company the amount of money they have set aside for your health care each month. The insurance company then uses this pool of money to pay claims.

If there is money left at the end of the month, the insurance company makes a profit that month.

If, however, claims exceed the amount the insurance company took in, they have to pay those claims out of their reserve fund.

To control costs and avoid "waste, fraud and abuse," many MA plans are built on HMO or PPO models. Both those models use networks of medical providers. Those networks have agreed to provide a discount for their services to people in the MA plan.

If you have a MA plan, you need to review it every year when you receive your renewal. Make certain that the network has not changed and the plan still meets your needs.

MAPD plans are MA plan that includes prescription drug coverage. Many of the PPO plans will allow you to fill your prescriptions at several of the major pharmacy chain stores.

MAPD plans that are HMOs will only allow you to fill your prescriptions at one of their approved pharmacies.

If you have a MAPD plan, you need to review which pharmacies are available. Those can change each year along with your doctors and hospitals.

If the approved pharmacies for the following year are not acceptable, you will need to make adjustments during your Medicare D Annual Enrollment Period.

Medigap/Medicare Supplement

If you have original Medicare with Medigap, you have no additional networks with which you have to be concerned. As long as your medical provider accepts Medicare assignment, your

Medicare Supplement insurance policy will be accepted.

For most of your life, you may have been covered with health insurance plans that required you to pay attention to networks. That is because insurance companies have negotiated discounts for their members in PPO or HMO plans.

As a rule, medical providers charge a different rate for the same procedure depending on the insurance status of the patient. Patients with private insurance can expect to receive a significantly lower bill from their doctor/hospital just because they have health insurance.

Patients without health insurance can expect to receive a significantly higher bill from their doctor/hospital.

Medigap plans do not have traditional "networks." That is because of the way they pay. Medigap is billed by Medicare, not your doctor. When you need to have medical treatment, you do not have to remember to ask your doctor/hospital if they accept XYZ insurance. All you need to ask them is if they accept Medicare assignment.

Since Medicare Supplement plans are regulated by the Centers for Medicaid and Medicare Services, aka CMS, they are not allowed to independently negotiate prices for their members.

As a result, there are no separate networks required by any insurance company offering one of the CMS approved Medigap plans.

Medicare Select

There is a type of Medigap that requires "networks." Those plans are called, "Medicare Select" plans. One Medigap provider, Blue Cross Blue Shield of Texas, describes Medicare Select plans as follows.

A Medicare Select option works like a standard Medicare Supplement policy. It has one significant difference. With Medicare Select, all scheduled inpatient hospital stays must be at a Medicare Select Network Hospital in order to have coverage for the $1,100 Medicare Part A deductible.

Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at the time of hospitalization or if you still use a non-network hospital, you must pay the Part A deductible and any non-covered charges.

If you do not go to a Medicare Select Network Hospital for a scheduled non-emergency hospital stay, you agree to pay the Medicare $1,100 Part A deductible. However, in an emergency admission, you are covered at any hospital, regardless of whether you go to a Medicare Select Network Hospital."

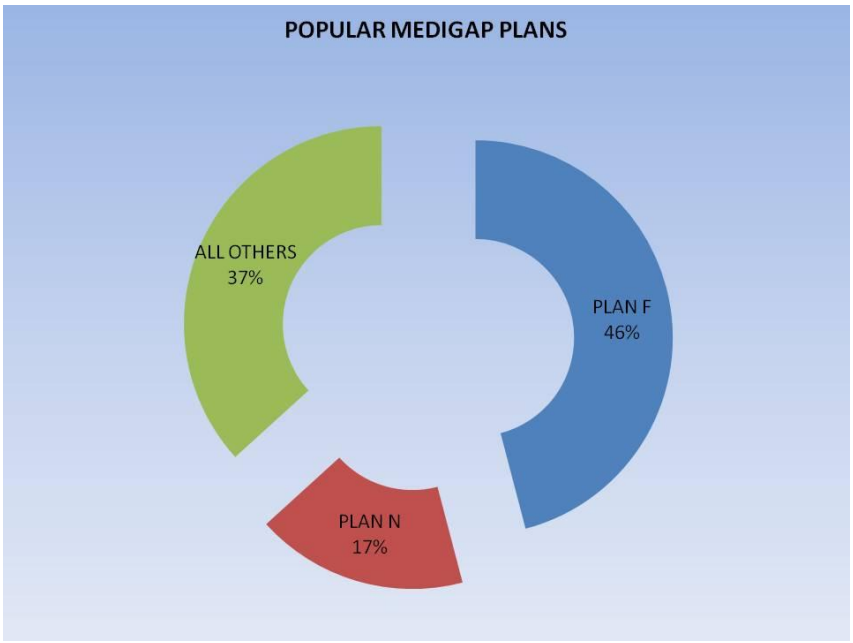
Medicare Select plans are normally much less expensive than traditional Medigap /Medicare

Supplement insurance. They are more restrictive if you have to be hospitalized. Most insurance companies will only sell a Medicare Select plan to people who live within a specified radius of a Medicare Select hospital.

Although it is not called a "network," it is important for you to remember that not all doctors or hospitals will accept Medicare. Some medical providers feel that the amount that Medicare authorizes for some procedures is not enough. They either do not accept Medicare patients or require them to pay more than Medicare.

You need to verify with your doctor or/hospital that he/she/they will bill Medicare on your behalf. As long as they will, you should never have any problems. If they don't accept Medicare assignment, you will have to pay them up front and then file a paper claim with Medicare to be reimbursed by Medicare and Medigap.

WHAT IS THE BEST MEDIGAP PLAN?



I am probably asked this question more often than all the other questions combined. It is a question that neither I, nor any other insurance agent, counselor or adviser can answer for you. You have to make a final decision with which you are willing to live.

The most popular plan in America is Plan F. It is the most comprehensive plan. It is also the most expensive. 47 % of people with Medigap have Plan F.

The newest plan that CMS has authorized is Plan N. It typically is about 80 % less costly than Plan F. Approximately 17 % of people with Medigap have either started with that plan or switched to it.

The remaining 36 % of Medigap policies is split between the other 9 plans.

In some cases, people have the Medigap plan that best combines their insurance needs with their budgets. Unfortunately, in many cases people have the Medigap plans best meets the needs of their insurance agent.

To purchase the best Medigap for you, follow the steps that I laid out in the preface to this book.

1) Read the CMS publication, "Choosing a Medigap: A Guide to Health Insurance for People with Medicare."

2) Only after you have decided which Medigap plan you want, work with a qualified insurance agent, whom you trust, to apply for Medigap. Tell him what you want. Don't ask him what you need.

3) When you receive the policy, make certain you take the time to read it. Make certain that it is the plan you wanted and that you understand your responsibilities so that you can make the most of your insurance.