MEDIGAP INSURANCE

(Medicare Supplemental Insurance)

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A. WHAT IS MEDIGAP INSURANCE?

Most elderly citizens who are enrolled in the Medicare Program will likewise be Social Security Recipients or dependant upon some other form of fixed income. Since their income is fixed at a certain level the exposure to liability for the co-insurance part of their medical bills as well as the payment of the deductible amounts is a matter of great concern and absolute fear for many. The fear has been heightened in many cases by the media and the intense publicity given increasing healthcare costs.

In order to decrease their exposure to these costs 20 million older persons will purchase **MEDIGAP or MEDICARE SUPPLEMENT INSURANCE.** Medigap insurance is private insurance designed to cover some of the medical costs not paid by Medicare. It is regulated by Section 1882 of the Social Security Act, the Baucus Amendment (P.L. 96-265, June 9, 1980 as amended). The statute stipulated minimum coverage requirements for all policies marketed as Medigap supplemental insurance. The law incorporated NAIC standards concerning terms of the policies and other requirements for the sale of these policies. The NAIC defines a "Medicare Supplement Policy" as a group or individual policy or subscriber contract advertised, marketed, or desgined primarily to supplement Medicare reimbursement. Section 3.74 of the Texas Insurance Code regulates these policies and basically tracks the NAIC definition. The regulations for Medigap policies are found at 28TAC §3.3301.

As a result of the abusive sales practices as well as misunderstandings about coverages of these polices Congress included language in the Ominibus Reconciliation Act of 1990 that took effect on November 5, 1991 (42 U.S.C. sec. 1395ss (1982), as amended by Omnibus Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388-135 that made drastic changes in these policies and the way they are marketed to consumers. As a result of the new law by July of 1992 the coverages of these policies were "standardized" into 10 basics policies. Elder law practitioners should review these policies and be familiar with the levels of coverage as many of their clients will be requesting help in understanding the differences in the coverages.

B. CORRELATION BETWEEN MEDICARE AND MEDIGAP FOR LONGTERM CARE

As previvously discussed in this paper Medicare has a limited benefit for nursing home care. Coverage by Medicare is limited to skilled level of care for 20 days with an additional benefit for 80 days with a copayment in 2003 of $105.00 for days 21-100 per spell of illness. The purchase of a Medigap policy can result in the copayment being covered for days 21-100 and in some cases for up to one year. Based on an average cost of $3500.00 per month there is the potiential savings to an elderly client or his family of $12,000.00 if these benefits are received. If a beneficiary is entitled to skilled nursing coverage through Medicare he/she is entitled by law to coverage for the same stay by a Medigap policy. Hence, if you get coverage from Medicare you get coverage from your Medigap policy.

Upon discharge from the hospital the patient will receive a notice telling them that they are being discharged from the hospital to a nursing facility. Every patient gets this notice as part of his/her discharge plan. More often than not this notice will state that the patient will not be eligible for skilled nursing care benefits from Medicare. Appeals of this denial of skilled nursing benefit have been found to be very successful. Some advocates estimate that the success rate of the appeal of such denials is 80% to 90%. There are many reasons for the success of these appeals but the most obvious one lies in the standards used to make the determinations of eligibility by the Cemters for Medicare and Medicaid Servics (CMS). Many times the policy manuals used by the entities making these eligibility determinations include guidelines set up by the CMS. These guidelines are CMS's interpretation of the Medicare law, but those interpretations are not always correct. Combine this use of wrong standards with the non-acquiesce policy of CMS and the end result is thousands of incorrect denials of benefits. the elder law advocate should closely examine any denial of skilled nursing care benefits and file appeals when indicated.