Health Insurance: "When You Are Over 65"

Home Economics • Cooperative Extension Service • Oklahoma State University

Virginia L. Solis
Assistant Family and Consumer Economics Specialist

Many Americans are living past the age of 65. With the advancements in medical technology and improved health care, older Americans can expect to live another 15 years as healthy and active adults.

However, not all individuals 65 and older lead healthy and active lives. The chances of developing a serious health problem or becoming frail increases with age. According to U.S. News and World Report, by the time you are 65, you stand a 50 percent chance of entering a nursing home in your remaining lifetime.

Two concerns people have about growing old are failing health and out living their money. Consumer Reports indicated the average annual cost in a nursing home in 1988 was $22,000. However, one can expect to pay $55,000 a year in 2018 if inflation stays at moderate rates. The question most people have is "Who will pay the bill?"

Health insurance takes on a new importance when retirement approaches. This publication reviews the various health care choices, helpful hints when buying health insurance, common terms found in policies, where to get help, and how to file a claim.

Health Care Choices

Health insurance is available from several different sources. Four things to consider before choosing a source are:

* types of benefits offered;
* premium amounts;
  what the coverage includes;
* is it available to you.

Government Health Care Insurance.

Medicare is a federally funded health insurance program for people 65 or over, and certain disabled persons of any age. You must meet specific requirements to be eligible for Medicare at 65. To find out what these requirements are, contact your local Social Security Office. If you are not eligible for Medicare, you can pay a monthly premium for coverage.

Medicare does not cover all health care costs nor was it designed to do so. Medicare has deductible and co-insurance amounts you must pay before coverage will begin. You can pay the deductible or co-insurance amounts either through coverage from another insurance plan or out-of-pocket. To enroll in Medicare, visit or call your local Social Security Office at least three months before you turn 65. Take proof of age.

Medicare Part A pays most of the costs of service in a hospital or skilled nursing facility. Blue Cross and Blue Shield of Oklahoma is responsible for the 1989 Part A contract in Oklahoma. Their offices are in Tulsa. If you have any questions about Part A, call collect (918) 560-3341.

Medicare Part B is a voluntary medical insurance program. Part B helps pay for physician's services and some medical services and supplies not covered by the hospital part of Medicare. Aetna Life and Casualty Insurance Company is responsible for the 1989 Part B contract in Oklahoma. Their offices are in Oklahoma City. If you have any questions about Part B, call them toll free at 1-800-522-9079.

For more information on Medicare, the Oklahoma Home Economics Cooperative Extension Service has an Alert Sheet called Medicare Roundup which further explains the benefits offered in Medicare Parts A and B.

Also, it is a good idea to visit your local Social Security Office and pick up a free booklet entitled The Medicare Handbook. It gives a detailed explanation of how Medicare works.

Medicaid is a program that helps pay medical bills for low-income people of all ages. It operates in every state through county and city welfare, public assistance, or public health offices. Medicaid covers nearly one-half of the cost of long-term institutionalized care for those who cannot afford it. Each state has its own definition of who is eligible. It is possible to have both Medicaid and Medicare, in which case Medicaid picks up payment of medical bills where Medicare leaves off. You may not qualify for Medicaid, if you have assets such as a house, car, and a few thousand dollars. Check with your local Social Security Office to see if you are eligible for Medicaid benefits.

The new **Medicare Catastrophic Coverage** Act of 1988 makes major changes in Medicare. This new law limits the amount a Medicare beneficiary pays for hospital care, physician services, and medical supplies. The new law limits outpatient drugs covered by Medicare, but increases the home-health care, skilled nursing facility, and hospice coverage. Breast-cancer screening and respite care benefits are also included.

You are automatically eligible for these new and improved benefits once you are a Medicare beneficiary. If interested in learning more about what the Medicare Catastrophic Act covers, contact your local Social Security Office. Ask for the booklet called Medicare Has Improved Catastrophic Protection and Other New Benefits. If you have any questions concerning this act, call the Medicare Catastrophic Hot Line number toll free at 1-800-888-1770.

Veterans Administration benefits are available to you, if you are a U.S. veteran, an eligible dependent, or a survivor of a veteran. The VA provides hospital and outpatient care for all service-related conditions.

Your local VA office has detailed information about benefits offered and your eligibility. A booklet entitled "Federal Benefits for Veterans and Dependents" is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Private Health Insurance.

Review your existing health care insurance policy or eligibility for additional government insurance before deciding whether you need to buy **supplemental insurance.** Medicare will not pay for all of your medical expenses. As a result of this, many private companies sell insurance to supplement Medicare. The Federal Government does not sell or service such insurance.

Supplemental policies have two purposes. One is to cover the co-payments not covered by Medicare. The second is to pay Medicare eligible expenses after Medicare's limit is reached.

Before you decide to purchase this type policy, you should know what Medicare does not cover. Since Medicare laws frequently change, make sure to check with your local Social Security Office for the latest version of the free booklet The Medicare Handbook. This booklet gives a detailed explanation of what is not covered by Medicare. The Alert Sheet Medicare Roundup mentioned earlier also discusses benefits not covered by Medicare.

Hospital Indemnity Policies are also known as supplemental insurance. These policies pay benefits only when you are hospitalized. Benefits are paid in cash for medical, non-medical, or supplementary expenses. These policies are not a substitute for basic or major medical protection but can be used along with them.

Frequently, people purchase these policies by mail. These policies promise to pay from $50 to $100 per hospitalized day. Since a single day in the hospital averages more than $460, these benefits represent only a small fraction of daily hospital charges. They offer no financial security once Medicare contributions are reduced or expire. Moreover, these policies do not begin paying benefits until you are hospitalized for several days. The average length of stay in the hospital is seven days, therefore, the average

benefit return does not justify the premium cost. You need to consider if the cost of the additional premium is worth the small monetary amount you might receive.

Dread Disease Insurance covers medical expenses for a single disease such as cancer or a group of specified diseases. Most often these policies sell through the mail, in newspapers and magazines, or by door-to-door salespeople working on commission. They encourage customers to purchase this insurance by stirring up unrealistic fears toward diseases, usually cancer. Consider the likelihood that any one specific illness will befall you. It is probably better to increase the limits on a policy that covers most illness.

Blue Cross/Blue Shield are nonprofit organizations that provide insurance to members. Blue Cross provides hospital care benefits; Blue Shield provides surgical and medical services. You have the option to join either on a group or individual basis. Since they are nonprofit organizations, premiums cover only claims and administrative expenses. There are many plans to choose from and benefits can differ with each plan.

Health Maintenance Organizations (HMOs) are health care providers who operate on a prepaid basis. HMOs directly employ or contract with selected physicians to provide you with health care services. HMO members pay a monthly fee for total health care services. HMOs' services range from periodic checkups to major surgery. Some provide vision and hearing care for an additional fee. The philosophy behind HMOs is that preventive care will lessen future medical problems.

Medicare patients have a choice between private physicians or joining a health maintenance organization. Advantages of an HMO are reduction of the cost of health care services and elimination of claims filing. Disadvantages may be less choice in selecting a personal physician and inconvenient location of facilities.

Two other forms of HMOs are Preferred Provider Organizations and Independent Practice Associations. **A Preferred Provider Organization** (PPO) is a group of medical care providers who contract with a health insurance company to provide services at a discount to policyholders. **An Independent Practice Association** (IPA) provides care through independent physicians who are under contract with the HMO. Any of the HMOs will provide or arrange for health care through hospitals, physicians, and specialists.

Long-Term Care Insurance is a rapidly changing new product from the insurance industries. Long-term care insurance helps with the cost of chronic illnesses or disabilities by financing long-term health care. However, no policy provides total coverage for all expenses.

Premiums for long-term care policies vary widely depending on age, number and type of restrictions, and amount of benefits. Premiums can range from several hundred to thousands of dollars per year, depending on coverage and age insured.

When reviewing a long-term care insurance policy, be sure to look for key features. Determine if the policy covers custodial care. Most policies do not cover custodial care unless the patient first receives skilled or intermediate nursing care. Does the policy have a pre-hospital requirement? Many policies require prior hospital stay before they will cover health care benefits. Another feature to consider is if the policy specifies a nursing home facility requirement of primarily skilled nursing and certified by Medicare. Most nursing homes in the United States are not skilled nursing facilities and many are not certified by Medicare. The fourth feature to consider is if the policy offers an inflation protection option that automatically increases your daily benefit by a set percentage each year. The last feature to consider is if the policy is guaranteed renewable. This feature assures you the policy will not be cancelled for any cause other than failure to pay premiums.

Comparing long-term care insurance is difficult because benefits overlap and restrictions and limitations vary from policy to policy. When considering a policy, ask the insurance agent the following questions:

* Will the policy cover all levels of care?
* How long will the policy pay for a stay in

a facility offering skilled/intermediate care?

* How much per day will the policy pay for skilled and intermediate care?
* When do benefits begin?
* How long will benefits last?
* Are there any exclusions or limitations in the policy?
* Does the policy offer an inflation protection option which automatically increases your daily benefit by a set percentage each year?
* Does the policy cover Alzheimer's disease?
* What is the company's reputation?
* What does the insurance coverage cost?

Community Services. By taking advantage of services offered within a community, you can save on health care expenses for both you and your family. Your local health department or voluntary societies may organize free or nominal-fee services for immunizations, TB testing, blood pressure checks, blood cholesterol checks, and other medical services. Also, local health fairs perform a variety of medical services free or for a minimal charge.

Shopping for Health Insurance

Shopping for health insurance requires careful comparison of the many options available. Focus your attention on the company as well as the premiums charged.

The Company. Health insurance is available from more than 800 private insurance companies. If you have any questions about the company's reputation, check with the State Department of Insurance. They cannot recommend a company, but they may help in eliminating those that engage in questionable practices.

Ask about the company's "loss-claims ratio." This represents the percentage of premiums collected by an insurance company that are later paid out to reimburse the losses of the insured. The formula for the loss-claims ratio is: claims ratio = losses paid divided by premiums collected. The lower the claims ratio, the lower the return on the premium dollar paid. It is a good idea to purchase policies with high "loss-claims ratios" rather than low ones. A ratio of 50 percent or less is considered a low ratio.

Be especially careful if you are considering buying health insurance advertised through the mail. Advertising for such policies cannot possibly detail what is covered and what is not. Many of these advertisements intentionally leave out important restrictions and exclusions. You should never purchase insurance without first seeing the policy or the certificate of insurance for group policy members. If an agent or company will not allow you to study a policy for a few days, buy elsewhere.

Tips for Buying Health Insurance

The following are a list of suggestions when shopping for health insurance:

* Shop carefully before you buy health insurance. Policies differ widely in coverage and cost, and companies differ in their service. Contact different companies and compare policies before you select one.

* Do not buy excessive coverage by trying to cover 100 percent of your costs. A single comprehensive policy is better than several policies with overlapping or duplicate coverages.

* Buy a policy that repays you substantially for large expenditures rather than trying to insure against routine or predictable expenses such as checkups.

* Start a health care cost fund to cover routine expenses, deductibles, and co-insurance amounts.

* Buy and maintain adequate health insurance coverage based on your needs and ability to pay for it.

* Avoid buying a "dread disease" policy. Realize it would cover only one disease, not your total needs.

* Check your right to renew. Beware of policies that let the company refuse to renew your policy on an individual basis. Policies that automatically are renewable provide added protection.

* Inquire about the company and the agent with whom you are dealing. A company must meet certain qualifications to do business in Oklahoma. Agents must be licensed and carry proof of licensing showing their name and the company they represent. If the agent cannot show proof, do not buy from that person. A business card is not a license.

* Keep the agent's name and the company's name and address. Write them down or ask for a business card.

* Take your time when buying health insurance. Do not let a "short-term enrollment period" high pressure you. Good salespeople will not rush you. If you question a policy, ask the salesperson to explain it to a friend or relative whose judgement you respect.

* Beware of health insurance sold through the mail or in television and newspaper advertising. Check these companies with the State Insurance Commissioner and compare their offerings to those of a local, reputable company before buying.

* Consider the consequences of replacing an existing coverage because you think it is out of date. Changing policies may subject you to new waiting periods and new exclusions. Consider adding to your present policy if necessary.

The following is a list of helpful suggestions when buying the actual policy.

* Do not give false information on your insurance policy application. If you fail to mention a pre-existing condition, you may not receive payment when you need it.

* Do not be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses related to that problem.

* If you pay your premiums directly, it is cheaper to pay annually or quarterly rather than on a monthly basis.

* When you receive a policy, take advantage of the "free look" provision. You have 10 days to look it over and get a refund if you decide it is not for you.

The following is a list of suggestions to consider after you buy a health insurance policy.

* Know exactly what expenses your insurance covers.

* Review your policy every few years. Make sure you have coverage for your family's current situation as well as present cost of health care.

* Do not keep inadequate policies just because you have been a customer for many years.

* Keep your insurance policy in a safe place at home. Keep a master list of all insurance policies and policy numbers in a safe-deposit box. If the policy is lost or destroyed, request a replacement policy from the insurance company using the policy number from the master list.

How to Keep Health Cares Cost Down!

If you are interested in keeping your health care costs down, Family Living Topic T4136 "Managing Health Care Costs" discusses management of health care costs.

Health Care Insurance Terms

Actual charge is the amount a physician actually bills a patient for a particular medical service.

Cancelable policy. The insurance company has the option to cancel or change the policy at any time. Try to avoid these policies whenever possible.

Co-insurance represents the portion of medical costs shared by you and the insurance company after you pay the deductible. Usually you pay 10 percent to 30 percent and the insurance pays 90 percent to 70 percent, respectively. Some policies set a maximum amount for you to pay. After you pay the maximum amount, the insurer pays all of the covered services beyond that amount.

Coordination of benefits prevents you from collecting more than 100 percent of a loss. It also prevents duplicating or overlapping payments for the same expense from more than two or more health-care policies. If you have two or more policies, you may want to review them to see if any of them have this clause. If one does, there is a chance you are paying for useless duplication of coverage. Remember, it is usually more economical to buy the most insurance you can afford in one comprehensive policy.

Custodial care is care given to help with everyday activities such as bathing and dressing.

Customary charge is the amount a doctor or supplier most frequently charges for a particular medical service or supply.

Deductible is the amount you must pay before the insurer pays any benefits.

Diagnosis related groups (DRG's). Hospitals treating Medicare patients will be repaid according to pre-established rates for each kind of illness treated, based on the diagnosis.

Exclusions refers to treatment for illness and injuries that the insurer will not pay.

Guaranteed renewable policies must continue in force as long as the insured pays the required premium. This is the most common and desirable policy.

Hospices provide care in the home or in a home-like environment to terminally ill persons who are diagnosed as having 6 months or less to live.

Intermediate care is given in an institutional setting for those who are chronically ill and incapable of independent living.

Noncancelable policies must be continued in force until a specified age, such as to age 65, as long as the insured pays the required premium.

Optionally renewable policies. The insurance company can cancel or change the policy only at the time of expiration.

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals under contract to the Federal Government. PROs review the care provided to Medicare patients.

Policy limits are the maximum amounts an insurance policy will pay to reimburse a covered loss.

Pre-existing condition is a medical condition begun before the insurance policy was bought.

Reasonable charge or approved amount. Medicare payments for covered services or supplies are made on the basis of the reasonable charge decided by the Medicare carrier in your area. The amount approved is often lower than the actual charge.

Skilled care services must be performed by or under the direct supervision of a registered nurse.

Waiting period is when benefits will not be paid for a pre-existing condition until you have had the policy for a specified period.

Where to Get Help

If you have questions about a group plan, ask your former employer or your union or association officer. If your question is about an individual or family policy, contact your insurance agent or the insurance company directly. Always read your policy carefully.

If you have problems with a company licensed to do business in Oklahoma, you can get help from:

State Insurance Commissioner
1901 North Walnut
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828
(800) 522-0071 (in-state only)

When you write, be sure to include your name and address, the name of your company and agent, the policy type and number, and the details of your problem.

Filing Claims

In order for an insurance company to pay your claim, you will need to provide them with the following information. Your policy number; copies of all medical or hospital bills with your doctor's signature; a completed claim form which you can get from the insurance company and/or Medical Explanation of Benefit forms. Keep a copy of what you sent for your personal file. You may also need to sign a release form allowing the insurance company to get additional health information from your doctor. If your policy has an **assignment of benefits**, this means the doctor or hospital may file your claim forms for you with the insurance payment going directly to one of them.

If you have questions or problems concerning health insurance, call the State Insurance Commissioner.

Adapted in part from:

Stephenson, M.J. (1988). Risk management: Health insurance when you are over 65. Fact Sheet 408. College Park, MD. University of Maryland, Cooperative Extension Service.

Prochaska-Cue, K. (1988). Nursing home insurance insights. HEG88-229. Lincoln, NE. University of Nebraska-Lincoln, Cooperative Extension Service.

References

Finday, S. (1989, January 23). Paying for long-term care. U.S. News & World Report, pp. 56-58.

Kapoor, J.R., Dlabay, L.R. and Hughes, R.J., Personal Finance, Irwin Homeward, IL. 1988.

"Who Can Afford A Nursing Home?" pp. 300-311, Consumer Reports, May 1988.

Additional Reading:

Department of Health and Human Services, Social Security Administration. 1988. The Medicare Handbook. Publication No. HCFA 10050. Baltimore MD.

Department of Health and Human Services, Social Security Administration. 1988. Should You Buy a Supplement to Medicare? SSA Publication No. 05-10039. Baltimore, MD.

Department of Health and Human Services, Social Security Administration. 1988. Medicare Has Improved Catastrophic Protection and Other New Benefits. Baltimore, MD.

Long-Term Care: A Dollar and Sense Guide, United Seniors Health Cooperative, 1334 G Street, N.W., Suite 500, Washington, DC 20005.

Peterson, E. (1988). Choice Time Thinking Ahead on Long Term Care. Aetna Life Insurance and Annuity Company. Hartford, CT.

Solis, V.L. (1989). T4138 Health insurance: Which policy to choose. Stillwater, OK. Oklahoma State University, Cooperative Extension Service.

Weber, J.A., Wright, A. and Risinger, P. (1988). Alert Sheet Medicare Roundup. Stillwater, OK. Oklahoma State University, Cooperative Extension Service.

Do you know the following information about the policy(s) you have?

1. Does the policy provide benefits for:

	Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No
a. Skilled care			
b. Intermediate care			
c. Custodial care			
d. Home health care			

2. What is the maximum the policy will pay per month for:

	Policy #1	Policy #2	Policy #3
a. Skilled care	$	$	$
b. Intermediate care	$	$	$
c. Custodial care	$	$	$
d. Home health care	$	$	$

3. The policy cost for one year is:

Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No

4. Can the company raise your premium over time?

Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No

5. Is the policy adjusted for inflation?

Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No

6. If you move or travel, will your coverage still apply?

Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No

7. Are there waiting periods before benefits begin for:

	Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No
a. Skilled care			
b. Intermediate care			
c. Custodial care			
d. Home health care			

8. Is a prior hospital stay required for:

	Policy #1 Yes/No	Policy #2 Yes/No	Policy #3 Yes/No
a. Skilled care			
b. Intermediate care			
c. Custodial care			
d. Home health care			

9. Are there limits or exclusions in the policy?

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