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MEDICARE 1990

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In December 1989, President Bush signed the bill that repealed the Medicare Catastrophic Health Act of 1988. This means that effective January 1, 1990, the coverage provisions reverted to those in effect in 1988. This publication will explain the basic coverage and costs to beneficiaries for 1990.

Who is Eligible?

There are no changes in eligibility for Medicare. Everyone who was enrolled still is. The change is that the extra coverage provided in the Catastrophic Health Act is now gone. Anyone who is not already enrolled in Medicare can sign up during the annual open enrollment period of January 1 to March 31. Coverage will begin on July 1 for anyone who enrolls in the first three months of the year.

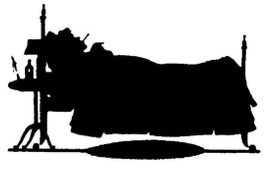
You can still decide to enroll for Part A (Hospitalization) only and pay no monthly fee (if you are fully insured). Or you can enroll for both Part A and Part B (medical services) and pay a monthly fee of $28.60.

What is Covered by Part A?

The same hospital services that were covered through 1988 are now included in Part A.

Inpatient Hospital Care.
Once again you must count days for hospital care and you must generally pay the deductible each time you enter the hospital. In 1990 that deductible is $592 and it covers the first 60 days of hospitalization.

For days 61-90 you must pay a daily co-payment of $148. While the countdown for days of coverage begins with each hospital stay, each person also has 60 reserve days that can only be used once in a lifetime. Should you use any of these days in 1990, the co-payment for each day is $296. You are totally responsible for any costs when those days are used up. As always, you will have to meet the Medicare requirements for hospitalization and will have to pay for non-medical things such as phone and television.



Psychiatric Hospital Care.
You still have 100% coverage for 190 days of psychiatric care during your lifetime.

Skilled Nursing Facility Care. There is a requirement that to receive skilled nursing care, you must be under hospital care first. There is no charge for the first 20 days of skilled nursing home care. For the 21st through the 100th days, you must pay a $74.00 daily co-payment. After 100 days, there is no further coverage in a year. This coverage is only for skilled care. That means that you must need the staff and equipment in a Medicare approved facility certified for skilled nursing care or rehabilitation. There is still no coverage for custodial care. That is the type of care that people need when they have trouble dressing, eating, or taking medications on schedule.

The spousal impoverishment protection that went into effect in the fall of 1989 remains. When one spouse must go into a nursing home and needs Medicaid to pay for this care, the couple is required to spend most of their assets first. Now the spouse who remains at the home is allowed to keep up to $12,000 in assets. If there are more than $12,000, that spouse can keep one half of the joint assets, up to $60,000. Additionally, that spouse can also keep monthly income, which currently is $786 per month. As always, the spouse living at home gets to keep basic assets such as the house.

Hospice Care. This care is limited to 210 days. A physician must certify that the patient is terminally ill. The patient must also abandon therapeutic treatment.

Home Health Care. Medicare will cover home health care if it is provided under a physician's treatment plan and care is only needed two to three times each week. If skilled care is needed five days a week for two or three weeks, Medicare may also pay.

What is Covered by Part B?
If you enroll in Part B and pay the monthly premium ($28.60), physician costs are covered by Medicare. You must pay a $75.00 deductible and 20% of the approved cost. If your doctor charges more than the approved amount, you must pay the difference. There is no limit on out of pocket costs.

Prescription Drugs.
The only significant prescription drug benefits are those available during hospitalization.

You Are Paying Extra Premiums?
Because the decision to drop Catastrophic Coverage was finalized so late in 1989, computers were already programmed to automatically deduct the anticipated premium from social security checks. Now the premium is less but the system will not make correct deductions until May. In the meantime, excess premiums will be deducted each month. To correct this problem, you will receive two checks for $10.60. One will be processed by the end of February and the other by the end of April. If you are on direct deposit, the refund will be sent straight to your financial institution. There is no way for you to receive the refunds early.

What Happened to the Tax Surcharge?
Although the 1989 Federal Tax Forms have lines for the surtax, <u>you do not have to pay it</u>. The forms were printed before the tax was repealed. If you paid estimated tax for the surtax, you can get your money back by filing for a tax refund. This means that if you made estimated tax payments for the surtax, you must file a return even if you do not owe any income tax.

What Should You Do About Your Medigap, Supplemental Health Insurance Policy?
The company you have your medigap policy with will be in touch with you concerning coverage provided by that policy and its premiums. You can probably expect your coverage to change. It may pay for things that Medicare paid for last year. As always, read your policy carefully and know what you are getting.

Do You Need a Nursing Home Policy?
This is a difficult question to answer. There is very little long term care provided by Medicare. You should fully evaluate your financial situation, policies available to you, and other alternatives for financing long term care.

You Still Have Questions?
One place you can call for more information is the Medicare Hotline (1-800-888-1998). It is open between 8:00am and midnight, seven days a week.