8-5-1988

1988 August 5 - Faculty Senate Retiree Newsletter

Faculty Senate, East Tennessee State University

FACULTY SENATE
East Tennessee State University
Box 23534A • Johnson City, Tennessee 37614-0002

August 5, 1988

Dear Retiree:

It is my understanding that you have already received information and an invitation to attend the Fall Faculty Dinner on THURSDAY, August 25, 1988, at 7:00 p. m. in the Culp Center. I hope you plan to attend and enjoy the opportunity to meet and talk with old friends.

Two significant events will occur as of January 1, 1989, that will affect all ETSU retirees. They are of a state and federal nature.

1. State Action:
   State Medigap Insurance Program - The questions of eligibility, benefits and sign up procedures will be made available to attendees.

2. Federal Action:
   Catastrophic Health Law - Here the question relates not only to benefits but the 1989 increased federal income tax liabilities under this law for anyone over 65 working or not working.

In addition, both of these prospective occurrences can have an impact on any personal medigap insurance policies you may now own individually and they could also change as of January 1, 1989, because of this federal law either in coverage areas or premium charges.

Finally, since the Fall Faculty Dinner is a time when the largest number of ETSU retirees get together, it was deemed appropriate to use this time to brief interested persons about these matters.

We will meet in the third level student cafeteria near the ballroom at 6:15 p. m. on that same Thursday evening just prior to that dinner. This will give you the opportunity to attend both of these two activities at one time.

Sincerely yours,

William J. Fisher

William J. Fisher
Retirement & Insurance Committee
Chairperson

Proposed Schedule
Medicare Supplement Policy

July 13	Complete preliminary review of: Plan of benefits Basic Administrative Framework Policy Provisions	Staff
July 15	Send materials to Review Group	
July 21	Meet with Review Group Review plan of benefits, policy provisions and implementation schedule	Staff
July 22	Review Recommendations concerning: Plan of Benefits Administrative Framework Policy Provisions	
July 29	Comments received from SIC/LEIC	
August 1	Complete RFP Complete mailing list of potential vendors	
August 4	Release RFP	
August 15	Proposers Conference	Staff and Consultant
August 18	Written Questions Due	
August 23	Release Responses to Questions	Staff and Consultant
August 30	Complete Evaluation Methodology	Staff and Consultant
September 8	Proposals Due	
September 22	Preliminary Evaluation Complete	Staff and Consultant
September 27	Evaluation Complete Complete Contract Draft	Staff and Consultant Staff
October (1st week)	Award Provide assessment of enrollment materials Provide draft of contract	 Staff Staff
October 7	Approve enrollment materials	Staff
October 14	Vendor supplied address tape	TCRS
October 27	Materials mailed to retirees	Vendor
November	Enrollment Period	
November 8-22	Run deduction tape test	Vendor/TCRS
November 30	Last day to send in enrollment cards	
December 9	Deduction tape provided by vendor	Vendor
January 1	Coverage takes effect	

STATE
MEDICARE SUPPLEMENT PLAN

ELIGIBILITY

Who Is Eligible

Those state employees or state teachers who are *eligible* to enroll in the State Group Insurance Program, Teacher Plan, or the medical plan of a pass-thru school system.

Includes spouses and Medicare eligible dependents of eligible state employees and state teachers.

Employees must be retiring from the State to be eligible.

Retirement Systems

State Group Insurance Program will include T.C.R.S. and TIAA Retirees; State Teachers will include retirees with T.C.R.S. and local retirement plans.

T.C.R.S. retirees will have their premiums deducted from their benefit checks. All other retirees will be on direct bill.

Spouse Who has lost Retirement Benefit

Spouse may *continue* coverage when they lose their retirement benefit or choose a lump sum by going to direct bill.

Employee Selects Refund

Employees who decide not to draw a monthly benefit and chose to withdraw their Retirement funds in a lump sum will not be eligible because they did not retire.

When Retirement Check Not Enough

If a retiree's check (T.C.R.S.) does not cover the entire premium, the retiree must be on direct bill.

ENROLLMENT

Open Enrollment

Using the eligibility rules above, enrollment will be for all retirees, spouses and Medicare eligible dependents of: (1) State employees who were eligible for the State Group Insurance Program, and (2) State teachers who were eligible for the Teacher Plan or teacher medical plan with the pass thru LEAs.

No pre-existing condition clause.

No proving insurable.

Retirement will send a list to the vendor of a employees who are eligible. The vendor will send applications and a booklet to those former state employees and state teachers.

U. T. will be asked to assist the State in obtaining names of eligible employees who retired on TIAA.

Subsequent Enrollments — Enrollment forms will be distributed to all state agencies and school systems to give to retirees.

Late Applicants — Retirees, spouses or Medicare eligible dependent children who elect coverage within 60 days of their retirement date or when they first become eligible will not have to prove insurable.

The Administrator will devise a system where they will determine if someone may join the Plan after the 60 day enrollment period by proving insurable. There will be a medical questionnaire to be completed or required physical. A letter of notification will be sent to the retiree of the vendor's decision. All decisions by the vendor on insurability of a late applicant will be made by the vendor and will be final.

Pre-Existing — There will not be a pre-existing condition clause on anyone in the Plan.

Administration of Plan — Complete responsibility for the administration of the plan will be with the vendor. It will be stated in the individual's certificate that T.C.R.S. will only be responsible for deducting premiums.

1989 YEAR STATE CONTRIBUTION AMOUNTS

1. More than 30 years of service — approximately $ 14.00 per month ($168 per year)
2. 20 to 30 years of service — approximately $ 10.00 per month ($120 per year)
3. 15 to 20 years of service — approximately $ 7.50 per month ($ 90 per year)
4. 15 or less years of eligible service — program available but not state funding

Finally, a health-cost cap

Catastrophic ills will bankrupt fewer elderly people, starting next year

The two-year struggle is over. This month, supporters of a greatly expanded health-insurance program for the elderly expect President Reagan to sign into law an overhaul of medicare benefits—the first since the program started in 1965. When the law takes effect next January, medicare for the first time will spring for unlimited hospital stays, will safeguard recipients against a crippling accumulation of physicians' fees and will begin sharing the cost of their prescription drugs.

Jacob Jimenez, 70, was lucky—his double-valve-replacement heart surgery meant only 33 days in the hospital, all covered by medicare. Under current law, he'd have begun paying on day 61

While not a perfect shield, the new law goes a long way toward protecting people age 65 and over and the disabled against the ruinous costs of catastrophic illness. After a deductible of $564 a year, their hospital tabs will in the future be paid in full by medicare, no matter how long the stay. Currently, only 60 hospital days are covered in full after payment of a $540 deductible. Further, the new law caps at $1,370 the amount that beneficiaries will have to pay each year out of their own pockets for doctors' fees. Outpatient prescription drugs, in the past the responsibility of the patient, will be partially covered. (For a description of the new benefits, see box on page 64.) All this added assistance will be expensive—Congress estimates the cost at $30 billion over the next five years. It will be paid for by higher medicare premiums and an additional income tax on high-income recipients. (See box at right.)

Help with medications. Of greatest value to the greatest number of people will be the doctors'-fee cap and the coverage of drug costs. According to congressional estimates, about 2 million elderly people spent more than $1,370 each of their own funds last year on doctors' bills. An estimated 6 million have out-of-pocket medication expenses that take big bites out of their income. Medicare will pay a percentage of prescription-drug costs beginning in 1991—starting at 50 percent and rising to 80 percent by 1993.

Not all people facing crushing medical bills will find relief. Contrary to what many elderly people believe, the bill won't ease the financial burden of long-term nursing-home patients who require simple custodial care—help with eating, dressing and bathing. It only covers short-term nursing-home or home care that consists of actual medical attention and that is prescribed by a physician. And although the bill does offer a straw of defense against financial devastation for the spouses of people who need long-term care—by guaranteeing that they can keep a certain amount of their monthly income and $12,000 in liquid assets—many elderly people will continue to face a severe depletion of their assets if they or their spouses need nursing-home care.

For many recipients, a beefed-up medicare system raises as many questions as it answers needs. One consideration will be whether to purchase or renew a private medigap policy, insurance that medicare recipients have relied on to fill in gaps such as deductibles and hospital co-payments—the share of the daily hospital bills medicare recipients now have to pay themselves after they've been in the hospital for 60 days. The medicare bill requires insurers to revise medigap plans to eliminate duplication of coverage, but medigap holders should still make sure that their policies do not overlap with the expanded medicare coverage. Come January, for example, you'll no longer need to worry about covering the cost of hospital co-payments. Instead, you should be focusing on plans that cover all deductibles, your share of your doctors' fees up to the $1,370 cap, and services medicare will not cover—routine physicals, immunizations and the cost of hearing-aid fittings, for example. Since these charges can quickly mount, the $500 or so you'll pay annually for an average medigap plan may be well spent. Says Joshua Wiener, a health-care analyst at the Brookings Institution: "I think a medigap policy is still going to be a good investment for most people."

Long-term care. If insurers have their way, medicare's lack of provision for nursing-home care will cause many recipients and soon-to-be recipients to conclude that the new long-term-care plans are a great investment, too. While you may want to investigate long-term-care insurance, terms vary greatly, and it's important to proceed cautiously. About

FOOTING A BIGGER BILL

Medicare beneficiaries will have to pay for their newly expanded health coverage through an increase in the medicare part-B premium, an additional drug premium and a supplemental federal income tax.

- From the current premium of $297 a year ($24.80 a month), the annual direct cost (including the increased part-B premium plus the new drug premium) will rise to $373 in 1989, $428 in 1990, $500 in 1991, $529 in 1992 and $571 in 1993.
- As has been true in the past, medicare premiums will be deducted from Social Security checks. No elderly person, however, will see any decrease in the size of his or her checks; rather, the checks might not increase as much as they otherwise would. A provision in the Social Security law called "hold harmless" prevents beneficiaries' checks from decreasing so much as to more than cancel out a given year's cost-of-living-allowance increase.
- The supplemental income tax will affect only the 40 percent of single beneficiaries with incomes above approximately $15,000 and couples with incomes above $20,000. The additional tax starts off at $22 for every $150 of income tax owed and rises to $42 for every $150 owed in 1993. In 1989, the maximum supplemental tax would be $800 for an individual and $1,600 for a couple. In 1993, the maximum would rise to $1,050 per individual and $2,100 per couple.

How the safety net will work

Where medicare has been reinforced

COVERAGE	OLD PROVISIONS	NEW PROVISIONS
Hospital inpatient care	First 60 days covered in full after $540 deductible for each hospital stay. Beneficiary pays $130 daily co-insurance (days 61-90), $260 (days 91-150). No coverage after 150 days. Lifetime reserve of 60 free hospital days.	All costs covered indefinitely; $564 deductible in 1989, $600 in 1990, rising thereafter. No matter how many hospital stays, you pay one deductible a year.
Doctors' fees	80% of all approved charges paid after $75 deductible. Beneficiary pays all costs beyond approved charges.	Same.
Cap, out-of pocket expenses for doctors' care (medicare part B)	No cap.	Cap of $1,370 per year, rising to $1,900 in 1993 on amount beneficiaries pay out of pocket—in co-payments and deductibles—for approved charges.
Prescription drugs	No coverage.	No coverage in 1989. 1990: Pays 50% of the cost of intravenous drugs used at home (annual deductible of $600). 1991: Pays 50% of the cost of all prescription drugs ($600 deductible). 1992: Coverage rises to 60%. 1993 and thereafter: Coverage rises to 80%.
Nursing-home care	Covers 100 days a year, with co-payment of $65 a day after day 20. Minimum three-day hospital stay required to qualify for coverage. Patient must need medical—not simply custodial—care.	Covers 150 days a year. Beneficiary pays 20% of average daily cost of first 8 days. Physician must certify medical care is needed; custodial care is not covered. No previous hospital stay is required.
Home health care	21 days per year of skilled-nursing care, generally limited to 5 visits per week.	38 24-hour days of skilled-nursing care per year when prescribed by a doctor. Extension possible in some cases.
Hospice care	Limit of 210 days. Pays up to $68 per day. Home care allowed.	No limit on days; other features unchanged.
Respite care	No coverage.	Covers up to 80 hours a year for nurse or home health aide to relieve family caring for patient at home. Available to those who exceed cap on doctors' fees or drug deductible.
Outpatient mental health care	Covers $250 a year.	Covers $1,100 per year. Visits to monitor medication dosage covered under part B and won't count toward this limit.
Low-income protection	State medicaid programs pay medicare premiums, co-payments and deductibles for beneficiaries with incomes below 80% of poverty level, which is now $6,870 for family, $5,440 for individual.	Medicaid will pay medicare premiums, co-payments and deductibles for beneficiaries with incomes below 100% of poverty line, and medical expenses of pregnant women and infants up to 1 year old whose family incomes are below poverty level.
Spousal impoverishment protection	Allow but don't require medicaid programs to protect assets of spouse. Most elderly have to "spend down" to poverty level to qualify for medicaid.	Medicaid programs must permit spouse of someone who enters a nursing home for long-term care to keep $786 of income per month—rising to $1,000 in 1993—and $12,000 in liquid assets. Homeownership, protected by other laws, is excluded.

70 companies now offer such "indemnity plans," which generally pay $25 to $60 a day in benefits for one to five years with no adjustment for inflation. A 65-year-old buying a plan today may not need coverage until he or she is 80; by then, nursing homes may cost an average $200 or more a day. The policies are also expensive, ranging from $600 to $800 a year for a 65-year-old to over $1,400 a year for a 75-year-old. Most have restrictions, too. People with a pre-existing illness such as Alzheimer's disease may be unable to purchase a plan. Most policies also require prior hospitalization for at least three days. A good plan will cover care in a skilled-nursing facility by doctors, nurses and therapists, *and* custodial care in a nursing home; also, it will be "guaranteed renewable," meaning the company has to renew the policy as long as you pay the premium. A growing number of home policies cover long-term care in your home, too.

Most long-term-care policies are less than adequate, *Consumer Reports* concluded in its May issue in rating 53 such plans. Their recommendations: If you're under 60, don't buy a long-term-care policy unless it provides some ratcheting up of benefits with inflation. If you're over 60 and of moderate-to-high income, a policy with at least an $80-a-day benefit and an unlimited number of days covered may be a "reasonable choice." If you're over 60 and of modest means, a long-term-care policy is probably a foolish expense, since you'll likely quickly qualify for medicaid and at least some of your assets will be protected.

Meanwhile, Congress doesn't view its job as over. Several long-term-care bills, including one that would significantly expand coverage of custodial-nursing care at home, have been proposed. Says Stephen McConnell, coordinator of Long Term Care 88, a national campaign to make long-term care a priority in the coming year: "The new coverage will help, but it doesn't solve the major problem. That's what we'll have to start addressing now." ■

by Steven Findlay

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The Retirement Letter®

BUILDING AND PROTECTING YOUR WEALTH FOR 15 YEARS

July 1988
Issue #236

Dear Subscriber:

SPECIAL REPORT
THE NEW CATASTROPHIC ILLNESS LAW...
AND WHY YOU STILL NEED SUPPLEMENTAL INSURANCE

After 2 years of exhaustive legislative review and revision, a catastrophic illness bill has finally become law. But before you cancel your supplemental insurance, take a good look at the new Medicare law. While it represents a good first step in protecting you from devastating health care expenses, there are still some big holes in the government's safety net.

My fear is that many people will rush out and cancel their "Medigap" insurance, thinking that the new Medicare coverage is all they need. Certainly, the changes--which represent the largest expansion of Medicare benefits since the program was initiated in 1965--will help prevent hospital bills from draining away your life savings. But your nest egg is still in jeopardy. That's why I've talked to health and insurance industry experts, as well as politicians, to get the inside story on what the law does not cover, and how to find insurance that does.

First, the Good News

As I said, the new law reflects a vast improvement over the previous benefits. The most important change is that Medicare will now pay 100% of hospital costs after an annual deductible of $564 in 1989. The deductible will rise with inflation in future years. Until now, Medicare would only pay hospital bills for up to 60 days, with a separate deductible for every hospitalization. That meant if you went in and out of the hospital over the course of the year, you could be hit with several thousand dollars in deductibles--payments you would have to make--before Medicare kicked in. On the other hand, if you were hospitalized for more than 2 months, you'd be forced to tap your savings to the tune of several hundred dollars per day. Hospital costs can easily top $200 just for a semi-private room. Add to that tests, medication, surgical procedures, physical therapy, etc., and you can easily see how even a sizeable nest egg could be wiped out by one serious illness or injury.

The new law protects you for both extended stays and repeated hospitalizations, by having a single annual deductible and no limit on length of covered hospitalization.

The new law also makes valuable improvements to the coverage of prescription drugs, another major expense for seniors. Starting in 1990, Medicare will cover 50% of of the cost of all intravenous drugs used at home, after a $600 deductible. Starting in 1991, Medicare will pay for half of all prescription drug costs, after a $600 deductible. The coverage will rise to 60% in 1992 and 80% in 1993, but the deductible will also rise to keep pace with the rising costs of medications. Still, with many folks paying $600 a month for prescription drugs, the new coverage will be a big relief--but not until 1990.

A little-known change in the laws is good news for retirees still covered by corporate medical plans. Due to the lower expenses your former employer will incur under the new rules, your former employer may be required to refund some of your money, or cut the amount you must contribute for this year and next. Make sure to ask.

Next, the Not So Good News

Congressional proponents of the new law have made a big deal over the expanded coverage of physicans' fees, but this change sounds better than it really is. Under the new provisions, Medicare will now limit a beneficiary's deductible to $1,370. Sounds good so far. The only hitch is that after the deductible, Medicare will pay 100% of Medicare-approved charges. Unfortunately, most health and insurance industry experts agree that Medicare's fee schedule is grossly outdated, and doesn't cover most doctors' charges. In fact, in many urban areas, the "approved charges" paid by Medicare represent only 1/2 of the actual bill--and the patient is still responsible for paying what Medicare doesn't.

The other disappointing change in the law concerns nursing home coverage. Proponents have advertised the expanded nursing home coverage widely, but they've glossed over a crucial detail: The coverage pays for skilled care only. The new law pays for up to 150 days in a nursing home, but only covers skilled care. The catch: Most nursing home stays over two weeks are for custodial care, not skilled care. And that's where the true threat to your nest egg lies.

Now, the Bad News

You see, the government still offers no insurance for long-term health care, represented by custodial nursing home care or home health care. On the same day that Congress passed the catastrophic illness bill, a proposal by Rep. Claude Pepper (D-FL) to consider a home health care bill was defeated before it even reached the floor. And the cost of long-term care is so tremendous that politicians and insurance experts alike are doubtful that any bill to provide insurance coverage will be passed in the foreseeable future.

How to Protect Yourself Now

So what should you do? What kind of insurance do you need--and how do you find the best policy?

I asked Robert DeLue, president of ACSIA (Associated California State Insurance Agencies) Insurance Services and a nationally respected health care insurance expert, these questions. He agreed that there is, in effect, no financial protection for long-term health care for retirees unless they go on welfare. Even the "Medigap" insurance you have is probably inappropriate.

Most Medicare supplements are based on the same "approved charges" fee schedule as Medicare itself. Usually, these policies won't make up the difference between your physician's bill and Medicare payments. In fact, DeLue suggests you reexamine your current policy in light of the new law and make sure you still need the supplemental "Medigap" insurance. If it doesn't cover any more than Medicare does now, you may be better off using those premium dollars to pay for a long-term care insurance policy.

For that's where the threat to your financial security lurks. As you know, I've been an advocate of nursing home protection for many years, and I recommend that everyone consider buying coverage while you are still relatively young and quite healthy. Why buy now? We've seen that the new catastrophic illness law will not cover custodial nursing home care, nor home health care expenses, so you must protect yourself. Furthermore, there is a definite advantage to buying younger. The rates are lower, and although they can be raised, your original application age will help keep the rate down. Of course, securing insurance now means that you'll qualify easily. And since most policies are guaranteed renewable, you won't have to worry about being turned down for coverage later in life.

I asked Mr. DeLue what one should look for in a long-term care policy and his response was simple: quality of the insurer. This is the single most important consideration in choosing a long-term health care policy, according to Mr. DeLue, because insurers don't have much experience in this area, and the stronger they are, the more likely they'll be able to meet their obligations. As I suggested in "Saving Money in Retirement" last month, look for an insurance company rated A or A+ by A.M. Best rating service. Look for a company that's been in business for at least 15 years, and one with a name you recognize.

Which carriers meet these tough standards?

Amex	John Hancock
Aetna	Equitable
AIG	

What to Look for

➤ Don't buy insurance from someone you don't know. This doesn't mean you can't conduct business through the mail, it just means that you must actually talk to an agent.

➤ Make sure he or she explains the policy fully and can demonstrate that the company has adequate administrative and customer service facilities.

➤ Get your agent's name.

➤ If you have any doubts about whom you're dealing with, ask for a reference or call your state insurance commissioner's office.

➤ Consider calling an independent insurance agent, who can tell you about different carriers and policies and is not trying to push one particular company. I recommend David T. Phillips (no relation to Phillips Publishing), 800/223-9610, in AZ 602/897-6088

➤ Make sure you get a receipt for any money you pay up front.

➤ If you don't receive a form letter confirming your policy in 7-10 days, call the insurance carrier.

As far as the specific benefits of various policies, Mr. DeLue says there's no longer much difference among policies. In the early days of long-term health care insurance, benefits varied widely. But because of legislation over the past 5 years, most policies are pretty standard. Most now cover custodial care, Alzheimer's disease, nursing home stays up to 7-10 years, even the effect of inflation on health care costs. (It can't hurt to double-check, of course.) And nursing homes themselves are being monitored more closely to make sure they meet industry standards.

On the Horizon

While a government-sponsored insurance plan for long-term health care may not be imminent, there are some advances on the horizon. First of all, experts predict that a policy covering home health care, offered by The Travelers, will soon be on the market. Right now, no one offers coverage for home health care. Look for that policy this year.

Secondly, look for prices to go down and benefits to improve. As more and more insurance companies enter the long-term care and home health care field, competition will heat up, with direct benefits for consumers.

Third, expect to see lifetime coverage offered soon. Originally, most nursing home policies covered up to a 5-year stay. Now many cover up to 10 years. The next move: Insurers will begin to offer nursing home coverage for an unlimited stay.

So there are many silver linings to the cloud of health care costs and the shadow they cast on your future financial security. Your best move now: Take the time to review your insurance coverage today and use the guidelines above to make sure your nest egg is safe.

THE KIPLINGER TAX LETTER

Circulated bi-weekly to business clients since 1925—Vol.63, No. 14

THE KIPLINGER WASHINGTON EDITORS

1729 H St., N.W., Washington, D.C. 20006 Tel: 202-887-6400

Cable Address: Kiplinger Washington D C

Dear Client: Washington, July 8, 1988.

Questions are pouring in on the new Medicare tax on the elderly. Readers wanting to know more about the new tax...how are they affected, who pays the tax, how is it calculated, when does it start and so forth. And questioning our June 10 Letter in view of what they've read elsewhere.

We thought we'd share our answers with you, for as often happens with a new tax, differences do exist between what we write and others say, many of whom skimmed the taxes in the new law...stressed benefits instead. So has Congress...it's no accident the new tax begins AFTER the elections.

Who pays the new tax? Everyone eligible for Part A of Medicare (hospital benefits) and paying a federal income tax of $150 for the year. Mainly folks 65 & over able to get social security, disability pensioners.

Can the new tax be avoided by waiving Medicare benefits? No.

What is the new tax based on? Your income TAX, starting in 1989.

What's the rate? For each $150 of income tax, you pay $22.50 more as a Medicare premium. If your income tax is $450, the added Medicare tax will be $67.50 ($450 ÷ $150, which equals 3. Then, 3 X $22.50 or $67.50).

Does the $22.50 rate increase later? You bet it does. To $37.50 in 1990. $39 in 1991, $40.50 in 1992, $42 in 1993. After 1993, indexed.

Must the new tax be figured only in increments of $22.50? No. IRS has authority to prorate the tax via tax tables...is likely to do so.

How much income must you have before new tax is owed? It depends on marital status, type of income...and, for non-itemizers, spouse's age.

TAXABLE income must be at least $1,000 for income tax to be $150 (the lowest 1989 income tax rate is 15%)...triggers the extra $22.50 tax.

To have $1,000 taxable income, singles 65 & over who don't itemize must have adjusted gross income of $6,900...drops to $1,000 taxable income by subtracting a $2,000 personal exemption and $3,900 standard deduction.

For couples, each of whom is 65, this means an AGI of $11,450... less $4,000 for personal exemptions and $6,450 for the standard deduction. With only one 65, $10,830...$4,000 exemptions, $5,830 standard deduction. (Our computations assume a 4% indexing of standard deductions for 1989.)

Of course, itemizers would start with a higher level of AGI.

What is the maximum amount of extra Medicare tax for 1989? $1,600 for a married couple, if both are 65 or older. $800 for a single person.

Do the maximums rise later? Yes. Annual increases push the lids by 1993 to $2,100 for couples 65 & older and $1,050 for singles 65 & over.

Who pays the maximums? Marrieds with TAXABLE income of $52,000. Singles, $27,500. These are for 1989. And remember, it's taxable income.

Why wasn't the tax publicized sooner? It was, in the Tax Letter. Benefits were highlighted in most press accounts. But Tax Letter readers were alerted to the tax aspects more than a year ago. On May 15, 1987, we said a Medicare tax of $840 a person was being developed by the Senate.

If your taxable income is—	Your 1989 supplemental premium is— SINGLE TAXPAYER	MARRIED FILING JOINTLY
Under $ 1,000	$ 0.00	$ 0.00
1,000	22.50	22.50
2,000	45.00	45.00
4,000	90.00	90.00
6,000	135.00	135.00
8,000	180.00	180.00
10,000	225.00	225.00
12,000	270.00	270.00
14,000	315.00	315.00
16,000	360.00	360.00
18,000	405.00	405.00
20,000	495.00	450.00
22,000	562.50	495.00
24,000	652.50	540.00
26,000	742.50	585.00
28,000	800.00	630.00
30,000	—	675.00
32,000	—	765.00
34,000	—	855.00
36,000	—	922.50
38,000	—	1,012.50
40,000	—	1,102.50
42,000	—	1,192.50
44,000	—	1,260.00
46,000	—	1,350.00
48,000	—	1,440.00
50,000	—	1,530.00
52,000	—	1,600.00

The premium surtax increases sharply in the coming years. For 1993, a single taxpayer who owes as little as $3,750 in income tax will pay the maximum supplemental premium of $1,050. A couple, each of whom is Medicare-eligible, will pay a surtax of $2,100 if their regular tax is $7,500 or more. In each case, that is a whopping 28% tax boost.

ESTIMATING YOUR PREMIUM ▶ You may be more familiar with the amount of your taxable income than with your tax liability. The table above shows the estimated amount of the premium for different taxable incomes.

Q. My spouse is eligible for Medicare, but I'm not. Most of our joint income is mine. Since I don't have to pay the supplemental premium yet, would it pay to file separate returns?

NEW MEDICARE COSTS AND DEDUCTIBLES

Part A

	1988	1989	1990	1991	1992	1993
Supplemental premium	None	$22.50/$150 of tax liability	$37.50	$39.00	$40.50	$42.00
Cap on supplemental premium	None	$800	$850	$900	$950	$1,050
Deductible	$540	$564		INDEXED		

Part B

	1988	1989	1990	1991	1992	1993
Monthly premium*	$24.80	$28.80	$29.70	$32.20	$34.00	$35.00
Deductible	$75	$75	$75	$75	$75	$75
Coinsurance	20%	20%	20%	20%	20%	20%
Limit on out-of-pocket costs	None	$1,370		INDEXED		

Prescription Drugs

	1988	1989	1990**	1991	1992	1993
Deductible	None	None	$550	$600	$652	
Coinsurance	None	None	20%	50%	40%	20%

*Includes new catastrophic coverage and prescription drug premiums.
**Applies only to immunosuppressives and intravenous drugs.

A. No. If you are married and file a separate return, the law treats *you* as Medicare-eligible if your spouse is eligible (unless you live apart). What's more, separate returns will not help if you are both Medicare-eligible but have unequal incomes. In this case, the law doubles the maximum supplemental premium that normally applies to single returns.

Q. Is the supplemental premium deductible as a medical expense?

A. No, it is not.

Q. Can I be hit with an estimated tax penalty if I wait until I file my return to pay the supplemental premium?

A. Yes, but only in tax years after 1989. Under the tax law, you are penalized if you fail to prepay through wage withholding or estimated tax payments at least 90%

Medicare Update: Figuring the Supplemental Premium, Remembering the Key Dates

The new Medicare supplemental premium is apparently causing a good deal of confusion. Everyone, it seems, it trying to come up with a different formula for showing how the tax will be calculated.

HERE'S HELP ▶ Rather than getting bogged down in numbers, it's best to simply repeat the basic rule: the supplemental premium is figured by taking the amount of tax you owe on your Federal return, dividing that by 150 and multiplying the result by $22.50.

Example: If you owed $600 in income tax, you'd divide 600 by 150, and get an answer of 4. Then you multiply 4 by $22.50, for an answer of $90. That means on an income tax liability for 1989 of $600, you would owe a supplemental Medicare premium of $90.

Of course, the question then arises, "What if I divide my tax liability by 150 and come up with a number between, say, three and four? Which number would be multiplied by $22.50 to determine my supplemental premium?" At this point, no one knows the answer for sure. The best bet is that the IRS will release brackets that will take care of such amounts.

Calendar of Effective Dates

While you're busy worrying about how much your supplemental premium is going to cost you, you may lose sight of when the other costs and benefits of the expanded Medicare coverage will take place. Here's a list of the key dates.

January 1, 1989

- Medicare Part A (hospitalization insurance) expands to cover an unlimited number of days of inpatient hospital care after payment of an annual deductible ($564 in 1989).
- Coverage of extended care in a skilled nursing facility is expanded from 100 to 150 days, subject to a coinsurance charge for the first eight days.
- Medicare Part B premiums go up to $28.40 per month, an increase of $4.
- Anyone eligible for Medicare coverage becomes liable for the new supplemental premium. For 1989, the premium is $22.50 per $150 of tax liability, up to a maximum premium of $800 per person.
- Companies offering group health benefits that duplicate at least 50% of the new Part A coverage must provide additional benefits of equal value or give rebates to plan participants who are eligible for the new Medicare benefits.

January 31, 1989

- Insurers offering Medigap policies must send a notice to policyholders explaining the new Medicare benefits and any duplication of coverage.

September 30, 1989

- States must change their Medicaid eligibility rules to protect the income and assets of spouses of individuals who require nursing home care. Spouse may now keep $786 in monthly income and $12,000 or half the couple's assets, whichever is greater. The monthly income allowance increases gradually until it reaches $950 in 1992.

January 1, 1990

- Medicare Part B becomes subject to a new catastrophic limit on out-of-pocket costs for physicians' services ($1,370 for

1990). Medicare pays 100% of all "reasonable" charges above the limit.

- Home intravenous drug treatment becomes covered under Part B, subject to an annual deductible of $550 and a 20% coinsurance amount.
- Beneficiaries who are dependent on daily in-home assistance with routine activities are eligible for 80 hours of respite care in the 12 months after meeting either the Part B catastrophic limit or the drug deductible.
- The monthly Part B premium rises to $29.70.
- The supplemental premium rises to $37.50 per $150 of federal income tax liability, up to a maximum premium of $850 per person.
- Employers offering group health benefits that duplicate at least 50% of the new Part B coverage must provide additional benefits of equal value or give rebates to plan participants who are eligible for the new Medicare benefits.

January 1, 1991

- Medicare Part B covers most prescription drugs used on an outpatient basis, subject to a $600 annual deductible and a 50% coinsurance charge.
- The monthly Part B premium rises to $32.20.
- The supplemental premium rises to $39 for each $150 of federal income tax liability, up to a maximum premium of $900 per person.

January 1, 1992

- The annual deductible for outpatient prescription drugs under Part B rises to $652, while the coinsurance amount drops to 40%.
- The monthly Part B premium rises to $34.
- The supplemental premium rises to $40.50 per $150 of federal income tax liability, up to a maximum premium of $950 per individual.

DRAFT
STATE MEDIGAP POLICY
FOR 1989

Service	Benefit	1989 Medicare A & B Pays	Plan 1 Pays	Plan 2 Pays	Plan 3 Pays
Hospital Costs (semi-private room)	Unlimited	All but $564 deductible	$282	$564	$564
Skilled Nursing Facility (SNF)	Days 1 - 8	80% of eligible SNF charges	--	20% of eligible SNF charges	20% of eligible SNF charges
	Days 9 - 150	Paid in Full	--	--	--
	Days 150 - 365	Nothing	--	--	80% of eligible charges after all Medicare days are exhausted. After participant's 20% co-payment equals $1,000, Plan will pay 100% of Medicare eligible expenses.
Physician Services	Not Applicable	80% of approved charges after $75 deductible	Deductible not reimbursed by Plan. 20% of Medicare approved charges. Maximum total payment by Plan of $1,370.	$75 deductible Up to 30% of charges with Plan payment not to exceed 100% payment of actual charges when coordinated with Medicare payment. Maximum total payment by Plan of $1,370.	$75 deductible Up to 30% of charges with Plan payment not to exceed 100% payment of actual charges when coordinated with Medicare payment. Maximum total payment by Plan by $1,370.
Prescription Drugs	Not Applicable	Nothing	--	50% of charges after participant pays $150 deductible. Maximum total payment by Plan of $500.	50% of charges after participant pays $150 deductible. Maximum total payment by Plan of $750.