Healthcare Advocates, Inc

www.healthcareadvocates.com

Selecting A Medicare Plan

Compare plans and costs

Get the answers you need to make educated decisions

A Message from the President

In the last twenty years, we've seen tremendous changes in healthcare—wonder drugs, laser surgery, DNA research—and it just keeps growing with each fantastic new discovery. While we've seen great changes in treatment, we've also seen great changes in the way we go about getting treatment. There are more insurance options than ever before—and lots to know before you decide which one is best for you.

At *Healthcare Advocates* our goal is simple—to get you the very best healthcare possible, no matter what kind of insurance you choose. We realize, however, that insurance plays a great role in your healthcare. For this reason, we've created this booklet to provide straightforward facts about the different kinds of Medicare plans. You'll learn the basics of each, including advantages and drawbacks, as well as answers to commonly asked questions. We've even provided a handy worksheet you can use to help you evaluate different plans before you make a decision.

Healthcare Advocates is committed to ensuring the healthcare you receive is the best it can be. Please remember, however, that this booklet is intended to serve only as a guide and should be read in conjunction with your health insurance benefits booklet. Also, we suggest that whenever you are considering a change in your insurance coverage, you consult your physician. It is important to know and explore all of your options, prior to making any changes. *Healthcare Advocates* assumes no liability whatsoever for the actions you make as a result of the information contained in this booklet.

We hope you find this information helpful, and as always, when you have questions, just call. *Healthcare Advocates* is your ally in healthcare.

Sincerely,

Kevin Flynn
President

Glossary

Term	Definition
Ceiling	The ceiling is the maximum out-of-pocket expense a person is required to pay for their healthcare prior to the insurance plan paying 100% for all further treatments. Note: Often there are limits on total insurance expenditures, generally between $1 million and $5 million. The insurance company's obligation ends after it reaches the specified limit.
Copay (coinsurance)	The patient's share of the cost. Depending on your health plan, you will be responsible for either a percentage of a charge or a flat fee.
Deductible	The portion of your medical expenses for which you are responsible prior to coverage beginning. The deductible for a family is greater than that for an individual.
Formulary	A list of drugs approved for use by a hospital or health insurer.
Gatekeeper	The gatekeeper is another name for a Primary Care Physician. See "PCP" in this glossary.
Grievance	The process by which a person may dispute denial of benefits or claims with their insurer.
HMO	Health Maintenance Organization.
Hospice	A pain management and care facility for the terminally ill.
In-network	The providers that are part of your HMO, PPO or healthcare network.
MediGap	A supplemental form of health insurance for Medicare participants.
Out-of-network	Healthcare providers that are not a part of your HMO, PPO or healthcare network.
Out-of-pocket	The portion of payment for which the patient is responsible.
PCP	Primary Care Physician. The physician who is responsible for coordinating a patient's healthcare, also referred to as the "gatekeeper."
Provider	Any hospital, doctor, nurse, clinic, etc. providing treatment or diagnoses.
Skilled Nursing Staff	A nurse or staff of nurses with specific skill sets.
Specialist	A physician that specializes in a particular type of medicine (e.g. a neurosurgeon). This person is generally not your primary care physician.

Health Maintenance Organizations (HMO)

Health Maintenance Organizations, also known as HMOs, use Primary Care Physicians to coordinate your healthcare. This physician, sometimes referred to as the "gatekeeper," is responsible for all of your care—from simple sniffles and broken arms, to physicals, wellness screenings and other common ailments. When you experience symptoms or problems outside the primary care physician's area of expertise, your primary care physician refers you to a specialist for care. The specialist—a surgeon, obstetrician, cardiologist, etc.—treats you from that point on, however, the specialist reports back to the primary care physician to ensure everyone is working together for your healthcare needs.

The primary care physician serves as a central resource for your medical and health history. The philosophy is that a central physician who has access to all of your medical needs can best coordinate each recommended procedure and treatment, taking into account your past medical experiences. It is not the intention of the primary care physician to limit access, however, it is their responsibility to see to it that each patient's care is appropriate.

Under other types of insurance plans, patients often refer themselves to specialists for a broad range of reasons without the doctor receiving the benefit of full medical records. Self-referral can cost the insurance company a great deal of money, not to mention time lost to inappropriate therapy. The HMO model helps better direct care and control costs by negotiating costs for these services and ensuring that expensive medical tests and treatments are used appropriately.

Office visits with your primary care physician generally run between $5 and $25. Your cost for a specialist referral can range from $0 to $35. Generally, there are no deductibles and no pre-existing clauses. In addition, once you begin treatment all your needs are covered.

HMOs are a great option for many, especially because they include benefits such as low cost doctor visits, low cost specialist care, and preventive care plans. The primary drawback, however, is selection. As an HMO member you are expected to obtain all of your healthcare through one of the physicians in the plan. In addition, you are generally restricted to receiving care in the hospitals that are part of the plan. For many, choice is crucial, but as HMOs continue to evolve, some of those issues are diminishing. For instance, if your doctor is not part of the managed care plan being offered, you have several choices. You can select one of the doctors in the plan, or you can ask your doctor to become part of the plan. Many HMOs are inclusionary, meaning they welcome doctors into their network, provided they meet credentialing criteria. The good news is that as HMOs grow in popularity, more and more doctors are becoming affiliated with one or more of the plans. There are even some programs where the HMO will pay for care outside the network if it can be shown that the best care for treatment exists elsewhere.

Another primary complaint from HMO members is access to care. HMO members must obtain a referral from their primary care physician (PCP) before seeing a specialist. If you fail to obtain a referral you will most likely be responsible for the specialist's bill yourself.

The good news here is that some HMOs are instituting direct access care for specialists such as OB/GYNs and optometrists. Rather than seeing a primary care physician first, patients can make their appointments directly with these specialists.

Emergency room visits are another complicated area for some HMO members. Your HMO provider will publish a list of certain emergencies such as uncontrollable bleeding, loss of consciousness, severe pain, high persistent fever, etc. Under those circumstances, you are to proceed to the nearest medical facility regardless of its affiliation with your healthcare plan. Most plans ask, however, that you notify them of the emergency situation within 24 hours of its occurrence. Failure to contact the HMO may result in denial of coverage if the problem turns out to be a non-emergency matter. Problems not listed on your emergency listing require you to call your health plan prior to entering the emergency room. However, HMOs are supposed to judge your case by your symptoms, not the ultimate diagnosis. Contact your HMO for details on your plan.

Sample Medicare HMO Disenrollment Form

{send this letter to your HMO via certified via, return receipt requested}

October 15, 2001

Ms. Jane Doe
321 Sky Drive
Doylestown, PA 18901

Re: Disenrollment
My HMO Member Number: 123-45-7890

To Whom It May Concern:

Effective immediately, I would like to disenroll from your organization's health plan and be returned to traditional Medicare.

Sincerely,

Jane Doe

Pluses of HMOs

• HMOs generally have less expensive monthly premiums than other plans. Copays are minimal and deductibles generally do not exist.

• HMOs generally do not have pre-existing conditions clauses.

• Because HMOs operate on the principle of preventive health, they often have health and wellness programs such as: health club programs, stress management, flu shots, smoking cessation and weight control programs.

• Your primary care physician coordinates all of your care through referrals and communicates with the other treating physicians.

• Because HMOs have no deductibles and minimal copays, the more you need healthcare, the more money you save.

• HMOs are trying to create a paperless system. Because of this there is very little paperwork and if you pay your copay at the time of their visit, you should never receive a bill unless you go out-of-network. Some are even eliminating the paper referral system. They electronically forward your chart to the treating physician.

Minuses of HMOs

• As a member of an HMO your selection of doctors is restricted to those listed in your HMO benefits manual.

• Prescription plans are generally limited to the medications listed on your HMO's formulary. Your physician can facilitate your HMO covering other medications if he or she determines the need.

• If you want to use a doctor or hospital that is not on your HMO's list, you will need special authorization or you will be responsible for the bill yourself.

• HMOs generally request that you contact them prior to going to the emergency room if your symptoms do not fall within the their definitions of an emergency. Failure to do so may result in the HMO denying payment of the emergency room bill.

• Different HMOs deal with issues of illness outside their service area differently. For example, if you were to become sick while visiting your mother in a different state, you may be responsible for some of or the entire bill. Your HMO benefits manual will list your responsibilities.

• If your children are covered under your policy and go away to school, be sure that the plan, or the school's plan, covers them wherever they reside during the school year.

Point of Service (POS)

Some HMOs offer a Point of Service (POS) plan. A POS plan is an HMO plan with the option to use out-of-network providers. If you use in-network providers, the plan works like an HMO and you will have a low copay and use a primary care physician. If you choose to go out-of-network, you will be responsible for a deductible and 20% - 30% of the physician's bill and any charges above your insurance company's UCR rate.

Medicare

Medicare is a federal insurance plan designed to insure people who are disabled or who are age 65 and over, and have either paid into Social Security or are eligible for entitlements under a current or former spouse. Medicare has two parts—"Part A" and "Part B". Part A generally pertains to your hospital and institutional benefits, while Part B pertains to your non-hospital benefits.

Medicare Part A

Medicare "Part A" covers medically necessary hospital care, skilled nursing facilities, psychiatric hospitals, rehabilitation and hospice care. Medicare's coverage is defined by a "benefit period." A benefit period begins the first day you receive medical treatment from a qualified hospital, hospice or skilled nursing facility, and ends when you have been out of the facility for 60 consecutive days. If you enter a facility again after 60 days, a new benefit period begins. If you re-enter the hospital within the 60-day period, you are considered to be receiving care as part of the original benefit period. With each new benefit period, all "Part A" hospital and skilled nursing facility benefits are renewed except for "lifetime reserve days*" or psychiatric hospital benefits that are used. There is no limit to the number of "benefit periods" you can have for hospital or skilled nursing care.

* Each Medicare recipient has 60 lifetime reserve days that may be used when the recipient chooses to use them. A lifetime reserve day is an extra day of coverage that is allotted when the Medicare recipient chooses (see chart on next page).

Summary of Medicare (Part A) Coverage: 2001

Services	Benefit	Medicare Pays	You Pay
Hospitalization	First 60 days 61st to 90th day 91st to 150th day* Beyond 150 days	All but $76 All but $190 a day All but $380 a day Nothing	$760 $190 a day $380 a day All costs
Skilled Nursing Facility Care	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $95 a day	Up to $95 a day
	Beyond 100 days	Nothing	All costs
Home Healthcare	Unlimited as long as you meet Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Hospice Care	For as long as a doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs and inpatient respite care
Blood	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	For first 3 pints

Medicare Part B

Medicare "Part B" covers medically necessary physician services, outpatient services, physical and occupational therapy, speech pathology, X-rays, laboratory tests and home healthcare if you declined "Part A."

Coverage also applies to certain ambulance services and durable medical equipment. Outpatient prescription drugs are not covered under "Part B."

Each year you are responsible for a $100 deductible. Once the deductible is met, Medicare "Part B" generally covers 80% of the Medicare approved amount for all medically necessary care. The "Medicare Approved Amount" is based on a nationwide fee schedule. This schedule assigns a dollar amount to every service a physician performs based on a number of criteria. If a physician, or other provider, charges more than "Medicare's approved amount," you are generally responsible for the difference. Be sure to ask if your physician or other provider accepts Medicare as payment in full (a/k/a "accepting assignment from Medicare"). If he or she does not, you are responsible for the portion of the bill above Medicare's approved rate.

Summary of Medicare (Part B) Coverage: 2001

Services	Benefit	Medicare Pays	You Pay
Medical Expenses	Unlimited if medically necessary	80% of approved amount (after $100 deductible) Reduced to 50% for most outpatient and mental health services	$100 deductible, 20% of approved amount and all charges above the approved amount
Clinical Laboratory Services	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
Home Healthcare	Unlimited as long as you meet Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Outpatient Hospital Treatment	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost	20% of billed amount (after $100 deductible)
Blood	Unlimited if medically necessary	80% of approved amount (after deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount for additional pints (after deductible)

Costs and Accessing Care under Medicare

As a recipient of Medicare you are entitled to all the benefits of "Part A" free of charge. You are entitled to these benefits because you or your spouse has paid into Social Security over the years. As a recipient you also are eligible to receive benefits under "Part B" though you must pay a monthly premium. In 1997 the premium was $43.80.

Accessing care under Medicare is much like accessing care under traditional insurance plans, provided that you have both Parts "A & B." Access to physicians, hospitals, and clinics is generally determined by you. Along with your open access to medical care you are entitled to benefits like durable medical equipment and specialized nursing though you need a prescription for these items.

For more information on Medicare, eligibility, entitlements and limitations contact the Medicare hotline at (800) 638-6833.

Medicare Supplemental Insurance (MediGap)

Medicare Supplemental Insurance is designed to fill the gaps in Medicare's coverage. This supplemental insurance begins where Medicare leaves off. Here is an example: the supplemental insurance pays the initial deductible and daily in-hospital copay for which you are responsible. It also covers the cost for additional blood, medical equipment, etc.

There are many different types of Medicare Supplemental Insurance. The basic plans cover your "Part A" deductibles and copays if you become hospitalized. The mid-level plans cover your "Part A & B" deductibles, copays, skilled nursing staff and at-home recovery benefits. The higher-level plans cover your "Part A & B" deductibles, copays, skilled nursing facility, at-home recovery benefits, a prescription plan and coverage for preventive care. Of course with additional coverage come additional premiums.

On the next page is a chart of the 10 standard Medicare supplemental plans (MediGap). Plan "A" is the "basic" MediGap plan, and the chart increases in the plan's coverage up to plan "J" which is the most comprehensive and expensive plan. On the left hand side of the chart is a list of benefits. There is a check-mark in the column of every benefit covered under the 10 plans.

Medigap Coverage

A	B	C	D	E	F | F*	G	H	I	J | J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At Home Recovery			At Home Recovery		At Home Recovery	At Home Recovery
							Basic Drugs ($1,250 limit)	Basic Drugs ($1,250 limit)	Extended Drugs ($3,000 limit)
				Preventive Care					Preventive Care

Basic benefits include:

- Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Part B coinsurance (20% of Medicare-approved expenses)
- First 3 pints of blood

Medicare HMOs

Medicare HMO plans are “wraparound” plans that incorporate traditional Medicare benefits with supplemental insurance and utilize an HMO provider network.

As a member of a Medicare HMO you will access care the same way an HMO member would. You are generally assigned a primary care physician (PCP) and gain access to general and specialty care through him or her. You also may be responsible for contacting your HMO prior to being treated in an Emergency Room. Failure to do so could cause the HMO to deny coverage for non-emergency visits. For more information on HMOs read the section on HMOs in this booklet.

If you become a member of a Medicare HMO you must continue to pay your “Part B” premiums to Medicare. You are still part of Medicare, but your benefits are obtained through the HMO, not Medicare. The benefits of joining a Medicare HMO are no deductibles, more comprehensive benefits (e.g. well visits, prescription plans, etc. are included in the plan) and smaller copays (generally between $0 and $25).

Medicare HMO plans have different plan levels and payment schedules. Standard coverage may cost between $0 and $50 a month. Superior plans that provide greater benefits and lower copays, may cost between $10 and $100 a month. Again, it depends on the plan you choose.

You are not alone if you wonder whether you should join a Medicare HMO or stay on traditional Medicare. To help you decide, ask the physicians and hospitals in your area. Your local physicians and hospitals have daily experience with all of the health plans in your area and should be able to help you make an informed decision. If you join a Medicare HMO, and later decide that you want to switch back to traditional Medicare, you can. All you have to do to return is to send a letter to the Medicare HMO or the Social Security office asking to be disenrolled. In 30 to 45 days you can expect a notice that you have been disenrolled from the HMO. From that point, you no longer receive your benefits from the HMO, but from Medicare itself.

Getting Good Healthcare

Everyone wants good, quality healthcare. To ensure this, you need to be proactive. How do you do this?

Take responsibility for your healthcare, educate yourself and know your responsibilities:

- Read your insurance documentation and know what your plan's benefits and limitations are.
- Ask questions! Contact the customer support number for your insurance plan and ask them all of your questions.
- Learn what pre-authorizations are needed prior to obtaining treatment.
- Find out if you need to contact your insurance company prior to going to the emergency room.
- Ask if your plan has a health club incentive/program.
- Ask your plan if they have smoking cessation, weight loss, prenatal and/or stress reduction programs.
- Find out what benefits are covered while traveling out of state and out of the country.

Do you and your physician have a good relationship? Here are some questions to ask yourself that give you an indication of the relationship.

- Can you get helpful advice from your physician by phone?
- How long must you wait for an appointment?
- Will your physician refer you for specialty care?
- Does your physician tell you test results and follow your progress?
- Does your physician explain what is wrong, what is being done and what you can expect?
- Does your physician spend enough time listening to you and explaining his or her treatment plan?

In addition to knowing your responsibilities and developing a relationship with your physician you must also understand your options.

- Get second opinions.
- Get the latest research on your conditions and treatments.
- Ask about drug interactions.
- Ask about invasive and non-invasive alternatives.
- Ask the doctor how many cases of "this type" he or she has treated.
- Ask for full explanations.
- Contact organizations like the American Cancer Society for information and support numbers.

Insurance Information

Apprise	1-800-783-7067
Department of Public Welfare Helpline	1-800-692-7462
Health Care Financing Administration	215-596-1335
HGSA	1-800-382-1274
Independence Blue Cross	215-241-2400
Keystone Peer Review Organization	1-800-322-1914
Legal Hotline for Older Americans	1-800-262-5297
Medicare	www.medicare.gov
or	1-800-medicare
Medicare Fraud and Abuse Hotline	1-800-638-6833
Penna. Blue Shield (Medigap)	1-800-345-7808
or	717-763-6695
Penna. Dental Association (Senior Dental Care)	1-800-692-7256
Penna. Dept. of Insurance (Consumer Complaints)	717-787-2317
Pharmaceutical Assistance (PACE)	1-800-225-7223
PACE (Hearing Impaired)	1-800-222-9004
Railroad Retirement Board - Harrisburg	717-221-4490
- Pittsburgh	412-644-2696
- Philadelphia	215-597-2674
Social Security Administration	1-800-772-1213
Travelers-Railroad Retirement Medicare	1-800-823-4455
United Health Care (DME Regional Carrier)	1-800-842-2052
Veterans Affairs (Benefits Information)	1-800-827-1000
Wellmark (Part A Home Health & Hospice)	515-246-0126

Health Plan Comparison Sheet

Company Name	Sample	Plan 1 (fill in)	Plan 2 (fill in)
Plan Name	Sample Insurance Co.		
Monthly out-of-pocket premium (not including prescription coverage)	$25 + Part B Premiums		
Prescription Coverage	$30/month for unlimited generic drugs		
Type of Plan	POS		
Plan pays for:			
$ or % of hospital stay (copay)	$15		
Total number of inpatient hospital days covered	unlimited		
$ or % of office visit	$15		
May I see a physician who is out-of-network?	Yes, must meet deductible and 20% copay		
Are all of my physicians in network?	No		
Skilled nursing	Days 1–20, $0/day Days 21–100, $97/day		
Home healthcare	$0, for as long as needed		
Vision coverage	Yes		
Dental coverage	Yes		

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