ElderCare Online™

the internet community of eldercaregivers

www.ec-online.net

ElderCare Medicare Health Plan Analyzer

© 1999 Prism Innovations, Inc.
All Rights Reserved

ElderCare Medicare Health Plan Analyzer

Table of Contents

Introduction	2
Explanations of New Health Plan Options	3
Analysis and Cost	5
Doctors, Hospitals and Other Health Care Professionals	7
Paperwork	8
Extra Benefits	9
Prescription Drugs – An Important Extra Benefit	10
Convenience	11
Quality	12
Complaints	13
Other Questions You May Wish to Ask	14
Definitions of Important Terms	15

Introduction

The ElderCare Medicare Health Plan Analyzer™ is a helpful assistant that allows you to collect information on Medicare Health Plan options and decide which plan is best for you. Use the worksheets to collect information on cost, providers and benefits from health plans in your area. You must make the final decision. Our goal is to help you collect the right information to make sure all the "t"s are crossed and all of the "i"s are dotted.

You should consult the Health Care Financing Administration's website at http://www.medicare.gov or the Guide to Medicare that is mailed to you each year. These resources contain important information on Medicare policies, benefits and changes to the program. You may also want to use the Medicare COMPARE database on Medicare's website. This interactive database helps you find benefit and quality information on plans in your area.

The ElderCare Medicare Health Plan Analyzer is available free of charge from the ElderCare Online website at http://www.ec-online.net. You may download and print it for your personal use only. The ElderCare Medicare Health Plan Analyzer is copyrighted by Prism Innovations, Inc., the operator of ElderCare Online. Professional care managers and others should contact ElderCare Online about licensing this and other software assistants; Learning Resource Guides; and other copyrighted materials from ElderCare Online. If you would like to reproduce or redistribute this or any of the other contents of the website, please contact us for explicit written permission.

Note: This software assistant is intended to help you make the best decision regarding your health insurance needs. It is for educational purposes only. Please consult medical professionals, friends, relatives and trusted professionals before making your final decision. ElderCare Online does not endorse any specific Medicare Health Plan or type of health plan.

This software assistant is designed to be printed and bound, although you may want to keep it stored on your computer as well.

1. Print out the entire zipped file;
2. Punch three holes into the left margin; and
3. Secure it in a rigid cardboard folder.

This version of the ElderCare Medicare Health Plan Analyzer (Release 1.0) is intended to be upgraded, please forward your comments and suggestions to roboyoboy@worldnet.att.net.

Explanations of New Health Plan Options

Congress passed a law in 1997 that made changes to the Medicare program. The law includes a section called "Medicare + Choice," which creates new health plan options. The new health plan options are explained below.

Original Medicare Plan – The Original Medicare Plan is the traditional system, run by the Federal government, that covers your Part A and Part B services. Medicare pays its share of the bill and you pay the balance.

- Cost – You pay the Part B premium ($45.50 in 1998), Part A and Part B deductibles and the coinsurance.
- Providers – You can go to any doctor or hospital that accepts Medicare.
- Extra Benefits – You receive all the Medicare covered services, but no extra benefits.

Original Medicare Plan with Supplemental Insurance Policy – The Original Medicare Plan is the traditional system that covers your Part A and Part B services. Medicare pays its share of the bill and you pay the balance. You may purchase one of ten standard Supplemental Insurance Policies (Medigap or Medicare SELECT) for extra benefits. Some policies help pay Medicare's coinsurance amounts and deductibles.

- Cost – You pay the Part B premium. You must also pay an additional monthly premium for your Supplemental Insurance Policy. The premium varies by State and insurer, and often varies by age. Most policies pay Medicare's coinsurance amounts and some also pay for Medicare's deductibles.
- Providers – With Medigap, you can go to any doctor or hospital that accepts Medicare. With Medicare SELECT, you must use plan hospitals and in some cases doctors in order to be eligible for full benefits.
- Extra Benefits – You receive all Medicare covered services. Some Supplemental Insurance Policies also cover services the Original Medicare Plan doesn't

Managed Care Plans – A Managed Care Plan involves a group of doctors, hospitals and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Managed Care Plans include Health Maintenance Organizations (HMOs), HMOs with Point-of-Service (POS) options, Provider Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs).

- Cost – You pay the Part B premium. Some plans charge you an extra monthly premium. You may also pay the plan a copayment per visit or service. You will also pay more if you don't follow the rules. No Supplemental Insurance Policy is necessary if you join a Managed Care Plan.
- Providers – Your choice of doctors and hospitals varies by the type of Medicare Managed Care Plan you choose. HMOs and PSOs are usually more restrictive – you must use the plan's doctors and hospitals. PPOs and HMOs with POS options are generally less restrictive – you may use doctors and hospitals outside the plan for an additional cost.
- Extra Benefits – You receive all Medicare covered services. Many Medicare Managed Care Plans offer additional benefits not covered under the Original Medicare Plan.

Private Fee-for-Service Plan – You choose a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to reimburse

for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover.

- Cost – You pay the Part B premium, any monthly premium for the Private Fee-for-Service Plan charges and an amount per visit or service. Providers are allowed to bill you beyond what the plan pays, and you will be responsible for paying whatever the plan doesn't cover. You may pay more for services.
- Providers – You can go to any doctor or hospital.
- Extra Benefits – You receive all the Medicare covered services. Some Private Fee-for-Service Plans may offer additional benefits the Original Medicare Plan doesn't cover.

Medicare Medical Savings Account (MSA) Plan – This is a test program for 390,000 eligible Medicare beneficiaries. You choose a Medicare MSA Plan – a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA Plan and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay your medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but the money will be taxed. If you enroll in a Medicare MSA Plan, you must stay in it for a full year. You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Call 1-800-318-2596 for more information on Medicare MSA Plans. Medicare MSA Plans first became available in November 1998.

- Cost – You pay the Part B premium. You use the money in your Medicare MSA to pay for medical expenses. Unlike other Medicare health plans, there are no limits on what providers can charge you above the amount Medicare paid by your Medicare MSA Plan. If you use all of your Medicare MSA money, you are responsible for paying all of your medical expenses until you meet the deductible for your Medicare MSA Plan. That deductible can be considerably higher than those of other Medicare health plans. Your Medicare MSA can help pay these costs.
- Providers – Depending on the Medicare MSA Plan you choose, you may be able to go to any doctor or hospital, or you may be limited to a network of providers.
- Extra Benefits – Money in your Medicare MSA pays for things that the Original Medicare Plan covers, plus other services it does not cover. A Medicare MSA Plan may offer additional benefits the Original Medicare Plan doesn't cover, but it doesn't pay for them until you meet your annual deductible.

Religious Fraternal Benefit Society Plans – These plans are offered by a Religious Fraternal Benefit Society for members of the society and only members may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

Analysis and Cost

Medicare health plans may have differences among them, such as cost, choice of providers, extra benefits, quality, paperwork, complaints and convenience. Use this worksheet to ask questions that are important to you and compare the answers. The information you gather will help you compare plans and make the health plan choice that is right for you. Write in the plan names and the answers for each plan to keep a record. Each worksheet section begins with important information about the differences between the Original Medicare Plan and other Medicare health plans.

In all Medicare health plans, including the Original Medicare Plan, you must pay the monthly Part B premium. In the Original Medicare Plan, you must pay additional costs such as hospital deductibles and coinsurance. The Original Medicare Plan does not pay for prescription drugs. You may be able to cover these out-of-pocket costs by purchasing a Supplemental Insurance Policy (Medigap) or by joining one of the other Medicare health plans. The additional costs with these health plan choices depend on the plan's monthly premium (if any), copayments and whether providers are allowed to bill extra. Costs vary from plan to plan.

In some Medicare health plans, you must get all covered services from doctors and hospitals that belong to the plan. If you are in one of these plans, you may get services from doctors or hospitals outside your Medicare health plan, but you will be responsible for paying for these services. The exception is an emergency, or when you require urgently needed care and are out of the health plan's service area.

Call the Plan Does the Plan...	Plan A ( )	Plan B ( )	Plan C ( )
Contact Name and Phone Number for Each Plan			
Charge a Premium in addition to the Medicare Part B premium? If so, how much?			
Charge copayments for doctor visits? How much?			
Pay for prescription? How much?			
Charge more if a doctor or hospital is outside the plan? How much?			
Continued on Next Page			

Have maximum amounts it will pay for different services?			
Set limits on what doctors and hospitals can charge you?			
Charge a deductible or coinsurance for inpatient hospital services, home health or skilled nursing facility services? How much?			

Doctors, Hospitals and Other Health Care Professionals

In the Original Medicare Plan and the Original Medicare Plan with Supplemental Insurance Policy, you may use any provider who accepts Medicare. Private Fee-for-Service Plans provide similar choice. In a Medicare Medical Savings Account (MSA) Plan, you may be able to go to any doctor or hospital, or you may be limited to a network of providers. Many Medicare Managed Care Plans require that you use the plan's doctors, hospitals and other health care providers. They also may require a referral from your primary care doctor to see a specialist. Some allow you to visit certain specialists within the plan – like optometrists, gynecologists or psychiatrists – without a referral. If you like your current doctor, first ask if he or she belongs to any of the plans you are considering.

Call the Plan	Plan A ( )	Plan B ( )	Plan C ( )
Are my doctors in the plan?			
Is there a selection of the doctors, health professionals and hospitals that I might need?			
Can I get the doctor I want? Is s/he accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
What is the plan's policy if it does not have the type of specialist I need?			

Paperwork

For most services, Medicare Managed Care Plans do not require you to file a claim form. With the original Medicare Plan with a Supplemental Insurance Policy, Private Fee-for-Service Plans and Medicare MSA Plans, you may have more paperwork. You may have to pay for covered services when you receive them, and then wait to be reimbursed.

Call the Plan And Ask ...	Plan A ( )	Plan B ( )	Plan C ( )
Do I have to file claims myself?			

Extra Benefits

The types of services described in this section are in addition to services that are part of the covered services provided in the Original Medicare Plan. Supplemental Insurance Policies, Medicare Managed Care Plans and Private Fee-for-Service Plans often provide benefits not provided under the Original Medicare Plan.

Call the Plan Does the Plan cover/provide...	Plan A ( )	Plan B ( )	Plan C ( )
Routine physicals?			
Eye exams, glasses, contacts?			
Hearing exams and hearing aids?			
Dental exams and treatments?			
Programs that focus on helping members with specific, chronic conditions such as asthma, diabetes or heart conditions?			
Programs that address needs like respite care, caregiver services and other social services?			
Wellness programs and classes that help you lose weight, eat properly, stop smoking or exercise appropriately? Is there any charge?			
Other benefits you might be interested in:			

Prescription Drugs – An Important Extra Benefit and Convenience

Generally, the Original Medicare Plan does not cover prescription drugs. Some Supplemental Insurance Policies help with the cost of prescription drugs, and some Medicare health plans may cover some of the cost for prescription drugs.

Call the Plan and ask ...	Plan A ( )	Plan B ( )	Plan C ( )
Does the plan cover the drugs I use?			
May I use my regular pharmacy?			
Are mail-order pharmacies available?			
What is the annual or quarterly dollar limit on prescription drug coverage?			
Will I have to pay more if I prefer to use brand name instead of generic drugs?			
Is there a maximum out-of-pocket cost for prescription drugs? What is it?			
Does the plan limit the drugs that it pays for to those on a list of drugs (formulary)?			

Convenience

Location, hours of operation and similar details may be important to you. Contact each plan to decide if it is convenient for you.

Call the Plan And find out ...	Plan A ( )	Plan B ( )	Plan C ( )
Are the hours and location of its doctors, clinics and other health care providers convenient?			
Is my access to emergency care convenient?			
Are the doctors' offices, labs and other services convenient?			
How fast can I be seen for urgent (non-emergency) care?			
Is there a telephone hotline for medical advice?			

Quality

All Medicare doctors must be licensed in their State. Medicare certifies hospitals, nursing homes and suppliers. Medicare also requires that Medicare Managed Care Plans establish quality assurance programs to get a Medicare contract. Once operating, Medicare Managed Care Plans must meet standards set by State and Federal governments.

Beyond these basic standards, the quality of care in plans may vary. Three main types of information will tell you about the quality of care in Medicare health plans.

1) Accreditation. This is an additional seal of approval by a private, independent non-profit group, which evaluates and gives it an official status based on that evaluation. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the American Accreditation Healthcare Commission (AAHC).
2) Satisfaction Surveys. These surveys ask beneficiaries how well they believe a plan meets their needs.
3) Performance Measures. These are special reports that describe the provision of care, such as whether a plan regularly provides mammograms for women.

Ask ...	Plan A ( )	Plan B ( )	Plan C ( )
The Plan: Is the plan accredited by an independent group?			
Your friends and relatives: Do they like the plan? Do they get the care they need, when they need it?			
Where available: How does the plan compare on performance measures and consumer satisfaction surveys? (Consult the Medicare Compare database at http://www.medicare.gov)			

Complaints

You have a right to appeal many decisions concerning your Medicare benefits. In the Original Medicare Plan you are entitled to an appeal if you believe that Medicare should have paid, in whole or in part, for health care services or items you received. In addition, Medicare has a contract with local Peer Review Organizations to take your complaints about such as quality of care and to resolve disputes if you believe that you are being discharged from a hospital before you feel well enough to go home.

All other Medicare health plans must have a process for resolving your complaints in a timely manner. Your Medicare health plan must provide you with written instructions on how to file an appeal when you feel you are wrongfully being denied care. After you file an appeal, the health plan must review its internal decision to deny care. Ultimately, if your health plan does not decide in your favor, your appeal automatically goes to an independent review organization that contracts with Medicare. If your health could be seriously harmed by waiting the amount of time needed for a standard decisions, special rules apply and you are entitled to a decision within 72 hours.

Call the Plan and ask ...	Plan A ( )	Plan B ( )	Plan C ( )
If the plan has a patient advocate/ombudsman to assist members?			
What is the plan's record regarding complaints?			

Other Questions You May Wish to Ask

Write your questions below:	Plan A ( )	Plan B ( )	Plan C ( )

Definitions of Important Terms

Benefit Period – Starts the day you are admitted to a hospital or skilled nursing facility (SNF) and ends when you haven't received hospital inpatient or SNF care for 60 consecutive days.

Coinsurance – The percent of the approved charge that you have to pay either after you pay the Part A deductible, or after you pay the first $100 deductible each year for Part B.

Deductible – The amount you must pay before Medicare begins to pay either each benefit period for Part A, or each year for Part B.

Managed Care Plans – Managed Care Plans involve a group of doctors, hospitals and other health care providers who have agreed to provide care for Medicare beneficiaries in exchange for a fixed amount of money from Medicare each month. They include Health Maintenance Organizations (HMOs), HMOs with Point-of-Service Options, Provider Sponsored Review Organizations and Preferred Provider Organizations.

Medical Emergency – Includes severe pain, an injury, sudden illness or sudden worsening illness that you believe may cause serious danger to your health if you do not get immediate medical care.

Medicare Medical Savings Account Plan – A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Policy with a high deductible. The other part is a special savings account called a Medicare MSA. Medicare deposits money into the account to help pay medical bills. Medicare also pays the premium for the health policy.

Original Medicare – The traditional pay-per-visit arrangement that covers Part A and Part B services.

Peer Review Organizations (PROs) – Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Managed Care Plans and ambulatory surgical centers.

Primary Care Doctor – In many Medicare Managed Care Plans, they coordinate and provide most or all of your health care.

Private Fee-for-Service Plan – A private insurance plan that accepts Medicare beneficiaries.

Referral – Permission from your primary care doctor to see a certain specialist or receive certain services.

Religious Fraternal Benefit Society Plans – Health plan offered by a Religious Fraternal Benefit Society for members of the society.

Supplemental Insurance Policy – Many private insurance companies sell Medicare Supplemental Insurance Policies that fill the "gaps" in Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health plan.

Urgently Needed Care – Unexpected illness or injury that needs immediate medical attention, but is not life-threatening.