

Chapter Six

Supplementing Medicare Options to Pay for Health Care Costs Not Covered by Medicare

1. **INTRODUCTION.** Chapter Five described Medicare as a federal health program that provides both major medical coverage and coverage for medical expenses when an eligible person becomes ill. However, Medicare is not intended to pay for all of a Medicare beneficiary's medical expenses. When Medicare does not cover a medical expense, the beneficiary must pay for it. Medicare beneficiaries are also responsible for paying Medicare premiums, deductibles, coinsurance and excess charges. People on Medicare usually need another health plan, policy or program to pay for the things Medicare won't pay for. Individuals are encouraged to contact the HICAP Benefits Counseling program to help them understand what alternatives they may have to cover the gaps in Medicare.
2. This chapter outlines recent changes in the Medicare program and provides an overview of the current options available to supplement Medicare.
3. **CHANGES IN THE DELIVERY OF MEDICARE SERVICES.** The Balanced Budget Act of 1997 (BBA) and subsequent federal legislation changed the Medicare program to allow people on Medicare to receive their benefits in ways similar to private health care. Congress directed the agency that administers Medicare, the Health Care Financing Administration (HCFA), to phase in different initiatives to encourage contracts with insurance companies and other health plans for the delivery of Medicare benefits. (HCFA has since been renamed the Centers for Medicare and Medicaid Services.) Previously, Medicare beneficiaries could choose to receive their Medicare benefits either through traditional or original fee-for-service Medicare, or through Medicare Managed Care. However, the BBA made changes to fee-for-service Medicare and authorized the creation of new Medicare contracts referred to as Medicare+Choice (M+C) plans.
4. **Sources of Law.** Changes to the Medicare Program were enacted through the following legislation that impacts the Social Security Act: the Medicare Modernization Act of 2000; the Balanced Budget Refinement Act of 1999; the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996. Although Medicare is under the general administration of the Centers for Medicare and Medicaid Services (CMS), rules resulting from these bills and amendments fall under the jurisdiction of various federal and state agencies and CMS subcontractors. Each section in the chapter identifies entities responsible for implementation, regulation and enforcement.
5. **Changes to the original Medicare plan.** The changes that impact the original Medicare plan include both changes in how certain services are reimbursed and changes to the benefits offered under Medicare supplement insurance plans. Medicare supplement plans are sold by private insurance companies, but the benefits are set by federal and state law. These plans are commonly called "Medigap" or "Medsup" plans and are designed to coordinate with the original Medicare Plan. Two new Medicare supplement policies were added to the 10 standard plans (labeled "A" through "J"). The new plans offer the same benefits as Plans F and J, but have a high deductible for a potentially lower premium. In FY 2002 the deductible is \$1,620. The amount of the deductible can change in January of each year.
6. **New Medicare+Choice Plans.** CMS is authorized to contract with different managed health care plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider sponsored organizations (PSOs) and religious fraternal plans. Despite this legislative

initiative, Texas and most other states have experienced a significant decline in the number of managed care plans offered. In Texas, the managed care plans available are HMOs, although there is now one PSO. Beneficiaries who choose to enroll in managed care plans agree to receive Medicare services under the plan's network of providers and must abide by the referral system of the plan.

7. Another M+C plan now available is the private-fee-for-service (PFFS) plan. This new option allows private insurance companies to contract with CMS annually. It differs from a managed care plan by allowing members to go to any doctor, hospital, or other provider that agrees to accept the private-fee-for service plan's terms of payment. Members do not need a referral to see specialists. One company currently offers this option in Texas.
8. Although the BBA authorized other plans, no companies currently offer them.
9. **Medicare Basics.** To understand the gaps in Medicare, it is important to understand what Medicare covers under Medicare Part A (in-patient hospital insurance) and Medicare Part B (which pays for medically necessary medical services). The CMS publication *Medicare and You* provides useful information about Medicare benefits. This brochure is mailed to all Medicare beneficiaries in the fall and provides a consumer friendly description of what Medicare covers along with any changes to Medicare benefits for the coming year.
10. **IDENTIFYING THE GAPS IN MEDICARE.** Generally there are five categories of costs that Medicare beneficiaries usually have to pay out of their own packets. These coverage "gaps" include premiums, deductibles, coinsurance/copayments, excess charges and costs for services not covered by Medicare. The costs for each might be different depending on the situation.
11. **Premiums.** Both Medicare Part A and Part B have a premium. Most people eligible for Medicare are not required to pay the Part A premium. In some cases, people may be eligible for Medicare, but not qualify for premium-free Part A. (For instance, someone who is over 65 but who has not worked for the required period of time). These people can purchase Medicare Part A by paying a premium. See Chapter Five, paragraph 6 and 7 regarding eligibility for Medicare. Everyone who elects to have Medicare Part B pays a monthly premium (in 2002, the premium is \$54). The premium amount usually changed in January of each year. People who have health coverage from an employer when they turn 65 or otherwise become eligible for Medicare should find out if they need to activate their Medicare Part B coverage. Benefits counselors frequently find that individuals are paying the Medicare Part B premium when they don't need it.
12. Most people have to pay Medicare premiums out of their own pockets because this cost is usually not covered by health plans that supplement Medicare. However, people with limited income and assets may be eligible for Medicare Savings Programs to help pay these costs. Medicare Savings programs, administered by the Texas Department of Human Services, include Medicaid and the Qualified Medicare Beneficiary (QMB) Program, which pay the Part A premium, if there is one, and the Part B premium. The Specified Low Income Assistance (SLMB) and the Qualifying Individual 1 (QI1) programs pay only the Medicare Part B premium, but allow individuals to have a higher income to qualify. The Qualified Individual 2 (QI2) covers only a portion of the Part B premium. The Qualified Disabled Working Individual (QDWI) pays the Part A premium. See Chapter Seven for more information about Medicare Savings Programs.
13. **Other premiums.** In addition to the Medicare premiums, Medicare beneficiaries must pay the premium for any supplemental health plan they choose. The cost of the added premium will be a factor in reviewing how much additional coverage a person on Medicare will want to purchase. Some options, such as coverage from a Medicare contracted managed care plan or certain group retirement

plans, may not require an additional premium. Note: Some people who have had a Medicare supplement policy for years are now facing significant increases in their premiums. Although these people may not have a special protection to buy Medigap, it is still worth shopping for another policy, even if it means reducing the benefits they currently have.

14. **Deductibles.** Beneficiaries must also meet deductibles for both Medicare Part A and Part B before Medicare will pay. The amount of the deductible is usually a fixed amount. The amount can change annually in January. The Medicare Part A deductible (in 2002 the deductible is \$812) is paid per benefit period. A benefit period begins when the person is hospitalized and ends when the patient has been out of a facility for 60 consecutive days. Therefore, someone who has several hospitalizations in one year could pay more than one deductible in a year. The Medicare Part B deductible (\$54 in 2002) is paid annually. Medicare supplement policies and most group retirement plans cover the Medicare deductibles. In selecting a Medigap plan, a person can choose a plan that covers only the more costly Medicare Part A deductible, or a plan that covers both the Part A and Part B deductibles. Some Medigap policies also require an annual deductible for prescription benefits that are not covered by Medicare.
15. The QMB Program pays for the deductibles for Medicare Part A and Part B and any deductibles for Medicare covered services in a Medicare+Choice plan.
16. **Other deductibles.** Group retirement plans that supplement original Medicare may also have deductibles. For example, a group plan might cover the Medicare Part A deductible but have a deductible for medical visits. Someone who sees the doctor infrequently may never reach the annual deductible. On the other hand, someone who sees the doctor frequently will find that once the deductible has been met, the group plan will pick up any other costs.
17. **Deductibles in Medicare+Choice plans.** Managed care plans or private-fee-for-service plans may also have deductibles for services. The deductible amounts would be different from the deductibles in original Medicare. None of the Medicare+Choice plans in Texas currently have deductibles.
18. **Coinsurance.** Coinsurance is a percentage of the Medicare-approved costs that a beneficiary must pay. Both Medicare Part A and Part B require beneficiaries to pay coinsurance for covered services. Most Medicare Part B services require that the beneficiary pay 20 percent of the Medicare approved amount. In Medicare Part A, the coinsurance is a set per-day rate for days 61 through 150 and days 21 through 100 in skilled nursing home stays. These amounts can change in January each year. Since the change is not approved until after the printing of the annual *Medicare and You* publication, the coinsurance amounts for specific Medicare covered services will be out of date each January. Recent changes in original Medicare revise the way certain services are reimbursed. This new payment system is called prospective payment. Some of the services that are impacted by this new change include outpatient hospital, community mental health center services and ambulance services.
19. Medicare coinsurance and the new prospective payment system costs are covered benefits if someone buys a Medicare supplement policy or has a group retirement plan. Note: Some Medigap plans only pay the Medicare approved coinsurance amount. This means that any excess charges beyond what Medicare approves would be the responsibility of the beneficiary. Certain Medigap plans offer coverage for the excess charge, which is limited to 15 percent over the Medicare-approved charge.
20. Although most group retirement plans would cover coinsurance amounts, people need to review their plans to see if there are any dollar limits or excluded services. In original Medicare, someone could purchase a Medigap policy even if he or she has a retirement group plan. Agents selling Medigap

policies are required to review an applicant's existing coverage to identify where there would be duplication of coverage.

21. Only the QMB program covers coinsurance in either original Medicare or with an M+C plan.
22. Sometimes the term copayment is used in place of coinsurance. This term is more commonly used in Medicare+Choice plans. Like coinsurance, a copayment is an amount that the beneficiary pays out-of-pocket when for receiving a covered medical service. In Medicare+Choice plans, copayments are fixed amounts that are approved annually by CMS and are usually not covered by any other insurance or health plan. Medicare rules do not allow someone in an M+C plan to buy a Medigap policy or to be in two M+C plans at the same time. In certain situations, it might be possible for someone to have a Medicare+Choice plan and his or her own group retirement plan. A benefits counselor assisting such a person would probably want to contact the group plan administrator to determine how the two plans will coordinate.
23. Both Medicare managed care plans and the private fee-for-service plan charge copayments. The amount of the copayment is approved by the individual plan. Some copayments may have annual caps, while others require the payment each time a service is used. An example of copayments can be seen in the approved PFFS plan, Sterling Option 1. With Sterling PFFS, there is a per hospital stay copayment of \$350 each time someone is hospitalized. There are unlimited hospital days per stay, but if someone returned back to the hospital repeatedly, they could find themselves paying more than if they were in original Medicare. Similarly, most Medicare managed care plans also require inpatient hospital copayments. Remember that there are very limited options, if any, to find alternate coverage for M+C plan copayments.
24. **Excess charges.** Health care providers who participate in original Medicare can choose to accept Medicare "assignment." These providers are listed in a directory maintained by the Medicare carrier in each state. Assignment means that the provider agrees to accept the Medicare-approved amount for a certain service or supply as payment in full. Doctors who do not accept assignment may charge up to 15 percent above the Medicare-approved amount when treating a patient with original Medicare. The charge above the Medicare-approved amount is called an excess charge. The beneficiary is responsible for paying the coinsurance amount and the excess charge. Excess charges are covered as benefits in certain Medigap policies. People with retirement group plans should check their policy to see if the plan will pay for the excess charge.
25. Although assignment relates only to original Medicare, some of the M+C plans have additional excess fees that can be imposed upon the member. For example, the Sterling Option 1 PFFS plan charges a \$50 per-day penalty if a member does not pre-notify the plan about a non-emergency hospital admission. The added charge has a limit of \$500 per hospital stay. Similarly, there is a high-shared copayment for durable medical equipment for failure to pre-notify the plan. While most Medicare managed care plans do not charge excess fees, they can deny payment of a service if it was not medically necessary or if the service was a non-emergency and obtained from an out-of-network provider. Like the copayments in M+C plans, members must pay for these excess charges out of their own pockets.
26. **Services not covered by Medicare.** In addition to Medicare premiums, deductibles and coinsurance, there are several preventive services and other medical costs that Medicare does not cover. A beneficiary is responsible for the full cost of those services. Some of the most common excluded services include prescription drugs, routine physicals, foot care, dental care, eye exams and hearing aids. Some M+C plans offer these excluded services. Since Medicare supplement policies are designed to coordinate with Medicare, services that are not covered by Medicare will most likely not

be paid for by a Medigap plan. Some Medigap plans, however, do offer prescription benefits, emergency care while on foreign travel and routine physicals. Medigap plans covering these services will cost more since the plan versus Medicare is covering the benefit.

27. A benefits counselor should use the list of services not covered by Medicare to review how an individual's retirement plan covers services not paid by Medicare. National trends show that fewer group plans cover benefits beyond what Medicare covers. Some retirees complain that they can no longer afford the premiums for their group plan and have dropped their coverage even if they could not get it back.
28. The Central and Regional offices of CMS are responsible for M+C subcontracts. CMS approves or disapproves annual benefit plans, premiums and cost sharing amounts.
29. **SUPPLEMENTING MEDICARE.** Medicare premiums, deductibles and coinsurance could cause financial hardship to people on Medicare, especially those who live on fixed incomes. Following is an overview of the options available to reduce the gaps in Medicare and/or supplement benefits:
30. **Medicare supplement policies.** Medicare supplement insurance can help fill some of the gaps that Medicare alone will not pay. Medigap policies are sold through private insurance companies. To buy a Medigap policy, a person must be enrolled in both Medicare Part A and Part B.
31. There are 10 standardized Medicare supplement insurance plans, labeled "A" through "J." Each plan offers a different level of benefits. Companies must use the same identifying letters for their plans. All companies selling Medigap insurance must offer at least Plan A but do not have to offer any of the nine other plans. Companies are also allowed to offer plans "F" and "J" with a high-deductible option. Currently only the plan "F" high-deductible plan is offered by a few companies. The Texas Department of Insurance (TDI) publishes the *Medicare Supplement Insurance Handbook and Rate Guide*. The guide includes the names and sample rates of companies selling Medigap policies in Texas. It also includes general information about Medigap policies and shopping tips. This and other insurance publications for consumers are available on the TDI web site at www.tdi.state.tx.us.
32. Medigap policies help pay Medicare deductibles, coinsurance amounts and excess charges. In addition, plans C through J, pay for certain services not covered by Medicare. Medigap policies only pay for services that Medicare deems medically necessary, and payments are generally based on the Medicare-approved charge. Medigap policies would not cover either the premium for Medicare Part A (if there is one) or the Part B premium.
33. Note: Medigap policies prior to 1992 were not standardized. Some pre 1992 policies offer better benefits for the premium charged. Someone with an old policy does not have to switch to a standardized plan.
34. **Medicare Select policies.** Medicare Select is a type of Medigap policy that may provide a lower premium in exchange for using only providers on the insurance company's "network provider" list. An insurance company or an HMO can issue Medicare Select coverage. If the beneficiary leaves a Select plan, or the company stops offering the Select plan, the company must make available any non-Medicare Select policy it has on the market with comparable or lesser benefits.
35. **Regulation of Companies.** The diverse provisions related to changes to standards for original Medicare related to Medicare supplement policies may be issued as operation letters or as rules published in the Federal Register as draft and later as final rules. The Texas Department of Insurance regulates companies selling Medicare supplement insurance in the state.

36. **Summary of Medigap Benefits.** Plan A and plans B through J all provide these basic benefits to cover gaps in Medicare:

- Daily coinsurance for hospitalization expenses from the 61st through the 90th day of any Medicare benefit period. Medicare Part A coinsurance for any hospital confinement beyond the 90th day in a benefit period, up to an additional 60 days during a beneficiary's lifetime. (These are called inpatient "reserve days." A beneficiary may use these days when he or she requires more than 90 days in the hospital during a benefit period. When a reserve day is used, it is subtracted from the lifetime total and cannot be used again.)
- All Medicare-eligible hospital charges for a period of up to 365 additional days during the beneficiary's lifetime after all Medicare hospital benefit days are exhausted. (Benefits beyond what Medicare covers.)
- The reasonable cost of the first three pints of blood, or their equivalent, under Medicare Parts A, unless replaced.
- The 20 percent Part B coinsurance for Medicare-eligible expenses for medical services, including doctor bills, hospital or home health care, and outpatient hospital treatment, after the Part B annual deductible has been met.

37. **Additional benefits in plans B through J.** Following is a brief description of the combinations of benefits that are added to the basic benefits in plans B through J.

- **Skilled Nursing Facility Care:** Covers actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. (Available on plans C through J.) Note: This is not custodial care.
- **Part A Deductible:** Pays the entire Medicare Part A inpatient hospital deductible amount per benefit period. (Available on plans B through J.)
- **Part B Deductible:** Pays all of the Medicare Part B deductible amount per calendar year. (Available on plans C, F and J.)
- **Medicare Part B Excess Doctor Charges:** Pays some or the entire excess amount billed by providers who do not accept assignment. Plans F, I and J cover up to the 15 percent limit. Plan G covers only 80 percent of the excess charge. If the doctor accepts Medicare assignment, this benefit may not be needed.
- **Benefits beyond what Medicare covers:**
 - Foreign travel emergency: Covers 80 percent of billed charges for emergency care that Medicare would cover if provided in the United States. Care must begin during the first 60 days outside the United States. There is a calendar year deductible of \$250. Lifetime maximum benefit is \$50,000. (Available on plans C through J.)
 - At-home recovery: Covers doctor-approved, short-term, at-home assistance with activities of daily living while recovering from an illness, injury or surgery. Limited to seven visits per week by a qualified care provider. Pays actual charges up to \$40 per visit, with a maximum of \$1,600 per year. (Available on plans D, G, I and J.)

- Preventive medical care: Includes an annual physical examination, certain lab tests and other preventive measures deemed appropriate by a physician. Maximum benefit is \$120 per year. (Available on plans E and J.)
- Prescription drug benefits: Basic pays 50 percent of outpatient prescription drug charges after a deductible of \$250 per calendar year. To receive the maximum benefit of \$1,250 per calendar year, prescriptions would have to cost \$2,750. (Available on plans H and I.) Extended drug benefits offer the same coverage as basic but with a maximum benefit of \$3,000 per calendar year. Prescription costs must be at least \$6,250 to get the maximum benefit. People with high prescription or medical costs will probably not be able to get this plan unless they apply during their six-month open enrollment period. (Available on Plan J.)

38. **Understanding the cost of Medigap policies.** Despite the fact that the benefits under a Medigap plan are identical, the premiums can vary differently between companies for the same coverage. Medigap policies in Texas are either issue-age rated or attained-age rated. Issue-age premiums are based on the person's age when he or she purchases a policy. Attained age premiums will automatically increase as the beneficiary gets older. The increase is in addition to any general annual premium increase. Medicare supplement insurance is sold to qualified individuals or as group policies. A beneficiary must be a member of a particular group, association or organization to get group insurance coverage.

39. Other factors that affect Medigap rates include the person's gender, whether the person smokes or not, the area the person lives, and whether the policy has an elimination period before it covers a pre-existing condition.

40. **Consumer protections when buying Medigap Insurance.** A beneficiary may not need a Medigap policy if he or she has group health insurance through an employer or former employer, if he or she receives Medicaid or qualifies for any of the Medicare Savings Programs, or if he or she belongs to a M+C plan.

- **Open enrollment rights to buy Medigap (persons 65 or older):** Insurance companies must sell a Medigap policy to people who are at least 65 and who apply within six months after enrolling in Medicare Part B, even if they have existing health problems. These six months are called the "open enrollment" period. During open enrollment, an insurance company must allow the person free choice among all the Medicare supplement policies it offers. The open enrollment rights can be used more than once during this six-month period. For instance, a person could change his or her mind about a policy, cancel it, and still have the right to buy any other Medigap policy, so long as the sale takes place during the six months after the person first enrolled in Medicare Part B.
- **Texans with disabilities under age 65:** In Texas, people under 65 who receive Medicare because of a disability also have a six-month open enrollment period beginning the day they enroll in Medicare Part B. This open enrollment right is applicable to Medigap Plan A only. When the beneficiary turns 65, he or she will have a six-month open enrollment period during which any of the 10 plans may be purchased.
- **Guaranteed Issue Protection:** There are certain situations involving health coverage changes when a beneficiary may have a right to buy a Medigap policy outside of the six-month open enrollment period. This right to buy a Medigap policy requires Medigap companies to issue a policy without regard to the beneficiary's health or claim history. The protection allows a qualified beneficiary to purchase Medigap plans A, B, C or F from any company that sells these

plans, so long as the plan is purchased within a 63-day period that begins the day that the beneficiary lost coverage. Contact the HICAP Coordinator at the Texas Department of Insurance to obtain state rules regarding guaranteed issue protection. Similar to the open enrollment period, this protection applies differently to Medicare beneficiaries under age 65. Beneficiaries under age 65 have the right to purchase Plan A, but could also purchase B, C or F from companies that offer these plans to those under age 65. Because the company cannot deny the plan, or charge more because of health or claim history, under this protection, a beneficiary could get better coverage than during their initial open enrollment period. The qualifying situations are summarized below.

- A M+C managed care plan or private-fee-for-service plan decides to end its Medicare contract.
 - The beneficiary moves outside a M+C plan’s area.
 - The M+C plan fails to meet its contract obligations.
 - An employer group plan that supplements Medicare ends its coverage.
 - A plan ends through no fault of the beneficiary.
 - The beneficiary drops a Medigap policy to join a M+C plan or buys a Medicare Select plan for the first time, and then leaves the plan or policy within one year.
 - A beneficiary joins a M+C plan when he or she first became eligible for Medicare at age 65, and within one year of joining, decides to leave the plan.
- **Group Medigap insurance rights.** Group Medicare supplement policy rights are essentially the same as with an individual policy. Because the group might make decisions that are out of the persons control, members have the following protections:
 - If the group changes insurance companies, the new company must offer coverage to everyone previously covered. The new policy must cover pre-existing conditions that were covered by the old policy.
 - If a person leaves the group, the insurance company must offer to provide unbroken Medicare supplement coverage with an individual policy or continuation of the group insurance.
 - If the group cancels its coverage, the insurance company must offer the person either an individual policy continuing the benefits he or she had before or a different policy meeting Texas requirements.
 - **Free Look:** A policyholder can return a policy within 30 days from the date they purchased it and receive a full refund. Encourage a beneficiary to use this “free look” period to review the policy carefully.
 - **Renewability:** All Medicare supplement policies are guaranteed renewable. A company cannot cancel a policy or refuse to renew it unless the beneficiary made material false statements on the application or failed to pay the premium. However, the amount of the premium is not guaranteed. An insurance company may raise a premium, but may do so only once each year. If the person purchased an attained-age policy, a company may also raise the premium on the beneficiary’s birthday.

41. **Other Information about Medigap Insurance:**

- **Medicare supplement claims.** Doctors and other health care providers must submit Medicare claims to the Texas Medicare contractor, TrailBlazer Health Enterprises, or to the Medicare carrier, Palmetto (for durable equipment and supplies). In most cases, these Medicare contractors then send the Medigap claim directly to the Medigap insurance company.
- **Medicare appeals and complaints.** Medigap policies won't pay for services that Medicare does not deem medically necessary. Therefore, if the Medicare contractor denies the claim as medically unnecessary, the Medigap company won't pay it. A beneficiary has the right to appeal the decision to deny a claim. The appeal process is described in the Medicare Summary Notice that is mailed to the beneficiary. If the Medigap company refuses to pay a claim for a Medicare-approved charge or delays payment of a claim, a complaint can be filed with the Texas Department of Insurance.
- **Elimination period.** Even though a company must sell a policy during an open enrollment period, the company can require a waiting period of up to six months before covering a pre-existing condition.

42. **Unfair trade practice in the sale of Medigap policies.** Agents and companies may not engage in any of the following illegal activities:

- Knowingly making any misleading statement that causes someone to drop a policy and buy a replacement from another company. This is called "twisting."
- Using high-pressure tactics, including the use of force, fright or threat to pressure someone into buying a policy.
- Obtaining sales leads by using advertising that hides the fact that an agent or company may try to sell you insurance. This is called "cold lead advertising."
- Posing as a representative of Medicare or a government agency.
- Selling a Medigap policy that duplicates Medicare benefits or health insurance coverage the person already has. An agent is required to ask if the person has other health policies.
- Suggesting that something on the application be falsified.
- Using misleading advertisements made to look like mail from a government agency by including eagles or similar graphics or official-sounding government bureaus on the return address

43. **Money-Saving Tips:**

- Standardized benefit plans make price shopping easy. Use TDI's rate guide to compare the prices of the plans that are of interest to the beneficiary.
- Consider other factors. Price should not be the only consideration. Learn a company's complaint record and A.M. Best financial strength rating by calling TDI's Consumer Help Line. Both are important indicators of the service a policyholder can expect from a company. Family and friends are other sources of information about a company's customer service. Be familiar with the independent agents in your area. They have any experience with the companies being considered.

- Remind people to ask if their doctor accepts assignment. If the doctor accepts assignment, the person would not need the excess charge benefit offered by plans F, G, I and J.
44. **Other resources and Medigap-related information.** Consumer publications that address Medicare supplement insurance include the CMS annual publication *Guide to Health Insurance for People with Medicare, Choosing a Medigap Policy* and the Texas Department of Insurance publications *Medicare Supplement Insurance Handbook & Rate Guide*. CMS also has available on its Web site publications that provide greater detail about original Medicare. These publications can assist the benefits counselor in appeal a claim or denial of services. The TDI HICAP Coordinator has consumer publications from the Medicare Rights Center that include more information about Medigap supplement protections and rights. A kit and year's subscription to their bi-monthly newsletter *Medicare Watch* was provided to each local benefits counseling program. See Appendix A for a resource contact list related to Medicare supplement insurance.
 45. **EMPLOYER-RELATED HEALTH PLANS AND OTHER HEALTH COVERAGE THAT SUPPLEMENTS MEDICARE.** Some people eligible for Medicare may have the option to also get health coverage from a group health plan sponsored by an employer, union or association. A group plan may cover employees, possibly their dependents and retirees. People with employer-related coverage may not need to enroll in Medicare, even though they are eligible for it. Additionally, a retiree who no longer works but is still eligible for group health coverage as a benefit of retirement may not need to purchase other insurance coverage beyond Medicare.
 46. **Sources of law.** Employment related health insurance is not mandated by federal or state law. When an employer does offer it, there are Medicare rules that will dictate which plan (Medicare or the group plan) pays first. There are also recent federal laws that serve to protect people from losing health coverage. This section relates to Medicare's secondary payer rules and also the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Depending on what type of insurance a person has there may be different protections through other federal or state agencies.
 47. An employer-related plan (sometimes referred to as private group insurance) may change how Medicare pays a claim and will also affect when someone should enroll in Medicare Part B. Employer-related plans may also coordinate coverage obtained either through a Medicare supplement policy or M+C plan. As a benefits counselor, you will need to review whether there is duplication of coverage or whether to suggest that someone obtain additional coverage.
 48. Each employer-related plan is unique and the benefits will vary from plan to plan. Before discussing how employer-related coverage coordinates to fill in the gaps in Medicare, it is important that a benefits counselor understand certain aspects of this type of coverage. The benefits offered by an employer-related plan are not standardized like Medicare or a Medicare supplement policy. To understand what protections a group plan offers, you will have to contact the plan sponsor or review the actual policy or contract.
 49. **When does a person with employer-related coverage NOT need to enroll in Medicare?** If a person has coverage from a group plan – either because he or she is still working or is covered as a dependent by a working spouse – the person needs to review whether or not to enroll in Medicare Part B. The two sources for verifying this information are the Social Security Office and the benefits coordinator for the group plan. Federal rules apply that define the responsibility of a small versus larger employer group. The importance of reviewing this information will affect the individual in two ways. First, if Medicare will not be the primary payer (group plan pays first), the individual could pay the annual premium for Medicare Part B (\$648 in 2002) and find that no benefits are paid by Medicare. Second, the person could face either a monetary penalty for delayed enrollment into

Medicare, or could lose the open enrollment right protection to choosing a Medigap policy. For more information about these issues, refer to the CMS publications, *Medicare and Other Health Benefits: Your Guide to Who Pays First* and *A Guide for Persons on Medicare*.

50. **How employer-related plans work to cover the gaps in Medicare.** Employer-related plans do not abide by Medigap rules and are not required to coordinate with Medicare. Yet in many cases, a group plan will cover both the deductibles and coinsurance gaps in Medicare. Some plans also cover services that Medicare does not offer such as outpatient prescriptions, routine eye care and dental care. Most group plans will not pick up the costs of the Medicare Part A and Part B premiums or offer coverage for long-term care. Be aware that some group plans completely cover the benefits available under Medicare Part B. The group might advise retirees that they do not need Medicare Part B since the group plan pays the coinsurance. Alert the retiree that should the group ever stop offering a health retirement plan, the retiree would be subject to the late penalty for each year that they delayed enrollment.
51. **Understanding the cost of group plans.** Most persons eligible for group coverage pay a premium for this coverage. The amount of the premium is set by the group, as are any increases. Traditionally, group insurance is a good buy when the group includes both active employees and retirees. The premium for the group will be based in part on the number of claims submitted. A key attraction to group plans is the fact that most plans offer coverage for dependents that are not yet eligible for Medicare. The person eligible for Medicare must pay both the Medicare premiums and the group plan premium.
52. Recent trends show that employers are having difficulty covering the cost for health insurance and many have had to pass on part of the increases to their covered members. Compare the cost of the group premium against the premium for a comparable Medigap plan. Review how many of the Medicare gaps the plan covers, the copayments (amount paid by the policyholder) and what added benefits the plan provides, including what it offers for dependents. Should the person with the group plan ever have to drop it because of cost or the plan ending, the person would have the guaranteed protection to buy Medigap plans A, B, C or F.
53. **How employer-related plans work with Medicare.** The subcontractors that process Medicare claims are called fiscal intermediaries (Part A) and carriers (Part B). In Texas, the Part A intermediary is TrailBlazers Health Enterprises, and the intermediary for Home Health is Palmetto GPA. TrailBlazers is also the carrier for Medicare Part B services other than durable medical equipment, which is processed by Palmetto. The telephone numbers for each can be found in both the back of CMS publications and in the Medicare Summary Notice (MSN) that is issued monthly to beneficiaries.
54. Doctors and health care providers that work with Medicare are required to submit claims to the subcontractors. TrailBlazers and Palmetto are also responsible for provider education on Medicare changes. After the carrier or intermediary processes a claim, it will submit the “crossover” claim to the group plan or Medigap company on file for payment.
55. Medicare now assigns the upkeep of records pertaining to other health coverage through a separate carrier called the Medicare Coordination of Benefits Contractor. When someone first enrolls in Medicare, he or she completes an Initial Enrollment Form that asks about other health coverage. Any changes in coverage should be reported to the new subcontractor or to the claims carrier or intermediary.

56. **Denial of Services or Complaints.** If Medicare denies a claim, a person can appeal to Medicare as outlined in the MSN. If Medicare pays its portion of the claim and the group insurance plan denies or delays payment, a benefits counselor would need to refer to the group member handbook or the policy for recourse. Depending on the type of plan, a complaint can be submitted to the Texas Department of Insurance. TDI will advise the complainant of what other recourse is available.

57. **More about how group plans work.** Following is a list of information that a person should be familiar with regarding his or her group plan.

- How retirement or the death of the employee will affect coverage for dependents
- Whether the plan has a lifetime maximum? See the policy for a definition of lifetime benefit and find out what has been used to date.
- The policy's benefits coordination, limitations and exclusions. Review the policy.
- That it's possible to further supplement a group plan that offers added benefits with Medigap policy and sometimes with an M+C plan.
- Annual enrollment periods and whether it's possible to drop the group plan and get it back during the next enrollment.
- How frequently the employer changes plans or companies. This might require the policyholder to change doctors or to update his or her insurance information with Medicare.
- protections.

58. **Consumer rights under an employer-related plan.** To assist a client who has a complaint or question about their employer-related plan you will need to review the employer plan's benefit booklet. The following resources may offer further assistance related to state and federal monitoring of employer-related health plans.

- ERISA - U.S. Department of Labor

Some employment-related benefit plans are subject to federal regulation under ERISA. ERISA has authority over how plans are administered and who is eligible.

Division of Technical Assistance and Inquiries
2000 Constitution Ave. NW, Room N-5619
Washington, D.C. 20210
202-219-8776

www.dol.gov/dol/pwba/public/pubs/mwguide.pdf

- COBRA - Consolidated Omnibus Budget Reconciliation Act

COBRA is a federal law that requires employers with 20 or more employees to allow employees and their dependents to continue their group coverage under certain conditions. Some states extend the COBRA benefits beyond federal laws. COBRA interacts with Medicare secondary payer rules and also impacts eligibility between Medicare and COBRA coverage. See the CMS publication, *Guide to Health Insurance For People on Medicare* for more information about Medicare and COBRA coverage.

U.S. Department of Labor, Pensions and Welfare Benefits Regional Office
525 S. Griffin St., Suite 707
Dallas, TX 75202
214-767-6831

www.dol.gov/dol/pwba/public/health.htm

- Texas Department of Insurance

TDI licenses agents and companies that sell health and life insurance. It also issues rules regarding payment of claims and processes consumer and provider claims complaints. TDI also monitors insurance fraud abuse.

Consumer Protection, Life, Accident and Health Complaints Resolution
P.O. Box 149091 M.C. 111-1A
Austin TX 78714-9091
1-800-252-3439

www.tdi.state.tx.us

- Health Insurance Portability and Accountability Act (HIPPA)

Contact the Texas Department of Insurance or the Centers for Medicare & Medicaid Services (CMS)

HIPPA Help Line: 410-786-1565 (not a toll-free number)

www.hcfa.gov/medicaid/hipaa/online/default.asp

59. **Resources for Other Employer-Related Coverage**

- TRICARE (formerly CHAMPUS)
TRICARE FOR LIFE (TFL)

Provides expanded medical coverage for Medicare-eligible retirees and their qualified Medicare-eligible dependents. Must meet eligibility defined by the Department of Defense. A prescription program for military retirees, TRICARE Senior Pharmacy Program was also expanded.

1-888-363-5433

www.TRICARE.osd.mil

60. **Former Federal Employee Retirement Plans**

Not all former Federal employees are eligible for Medicare. Retirees should first contact their former employing office or retirement system. Information about current health plan options is also available from the U.S. Office of Personnel Management, Retirement and Insurance Services. Their web address is at www.opm.gov.

- Railroad Retirement Board

1-800-808-0772 for enrollment, lost RRB Medicare Card or address change.

RRB Medicare Part A intermediary – TrailBlazers Health Enterprises

1-800-442-2620

RRB Medicare Part B carrier – Palmetto GBA

1-800-833-4455

- Texas Employee Retirement System

1-877-275-4377

www.ers.state.tx.us/Retirees/Publications/medicarebrochure.html

- Teacher Retirement System of Texas

TRS Care

1-800-223-8778 for enrollment and eligibility mostly for retirees who worked for independent school districts. State colleges and public universities should contact their former employer or the state retirement system. For TRS health insurance complaints or claims call their health insurance subcontractor at 1-800-367-3636

For Level 3 coverage prescription questions or complaints call 1-800-713-0742

- Texas Health Insurance Risk Pool

For individual eligibility for health pool coverage. Coverage of last resort for eligible individuals under age 65 and in certain cases their dependents.

1-888-398-3927

1-800-735-2989 (TDD)

www.txhealthpool.com

- TexCare Partnership

Offers two health care coverage options for Texas children, Medicaid and Children's Health Insurance Program. Both programs cover children from birth through age 18. You can apply for both programs with a single application through TexCare Partnership.

1-800-647-6558

www.texcarepartnership.com

61. **MEDICARE MANAGED CARE OPTIONS, MEDICARE + CHOICE, MANAGED CARE PLANS.** In order to give Medicare beneficiaries more options to receive their health benefits, the federal government may enter into contracts with health plans that sell insurance to large groups. Managed care plans also referred to as coordinated care plans contract with Medicare to serve a specific geographic area usually designated by ZIP code or county. Managed care plans offer their members (persons who are eligible and chose to join these plans) all of their Medicare benefits through a network of doctors, hospitals and other related health care providers. A person who joins a Medicare managed care plan is no longer in Original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits.
62. When the Centers for Medicare and Medicaid Services (CMS) contracts with a managed care plan, CMS agrees to pre-pay a monthly fee for each Medicare beneficiary that enrolls in the plan. Contracts are usually for one year, and each year CMS will approve the benefits and any fees that the plan passes on to its members. Most managed care plans charge their members a monthly premium

(different from the Medicare Part B premium) and copayments. The amount of these is usually lower than what might be paid with a Medigap policy.

63. Copayments in Medicare have usually been defined as a set amount that the beneficiary pays as a shared cost for an approved service. The term copayments is used mainly with Medicare managed care plans and the amounts have traditionally been very low. In Original Medicare, this shared cost is called coinsurance and is a percent of the approved amount for a service. Recent changes in Medicare now use the term copayment in both Original and M+C Medicare plans. Many persons think that the copayments in HMOs continue to be small amounts such as \$5 or \$10 dollars. In reality, most HMOs have increased the amount of their copayments. In addition, new copayments for certain services needed as treatments for chronic illnesses such as radiation therapy are higher than the coinsurance amount that a person would pay under Original Medicare.
64. Under the Balanced Budget Act of 1997, the CMS was authorized to contract with different models of managed care plans beyond health maintenance organization (HMOs). The difference between the plans frequently has to do with how the entity is structured. Currently the only types of plans available in Texas are HMOs and a Provider Sponsored Organization, (PSO). Other models that Medicare can contract with include Preferred Provider Organization (PPO), Point of Service (POS) or Religious/Fraternal Organization (RFO). The latter if available is open only to members of a church or association.

Note: The number of Medicare managed care plans contracting with Medicare has been declining both in Texas and the nation. Each year, these plans make a business decision of whether to continue their contracts or to terminate them. The number of M+C managed care plans available in Texas is limited to major urban areas like Dallas, Fort Worth, Houston and San Antonio. To find out if an M+C managed care plan is available in a specific area call Medicare's toll free telephone available 24 hours a day at 1-800-633-4227 or use the interactive Medicare website:

<http://www.medicare.gov/MPHcompare/Home>

65. **Regulatory authority and sources of law.** The US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) is authorized to enter into contracts with federally qualified managed care plans to arrange or deliver services to Medicare beneficiaries. Subsequent legislation under the Balanced Budget Act of 1997, expanded the types of managed care plans that CMS could contract with as part of the federal campaign to expand Medicare choices. Although originally, these plans were required to have at minimum over 50 percent of their membership in the commercial market as a way of assuring risk of insolvency and to assure adequate network arrangements, CMS is allowed to waive these requirements.
66. The contract with CMS requires that a plan have sufficient administrative capacity to assure against fraud, provide adequate provider networks, and to develop processes for quality care improvement, appeals and grievances. They are also subject to external quality monitoring by independent CMS contractors called peer review organizations or PROS (state level contracts) and a national agent for reconsideration of managed care plan denials known as the Center for Health Dispute Resolution or CHDR. CMS region offices are responsible for state monitoring of managed care plans and the review of marketing and advertising materials.
67. In addition to meeting federal requirements, managed care plans must meet state licensure requirements, although state laws can not conflict with or be more stringent than federal rules. The Texas Department of Insurance does not have a formal role in the application review process although

federal law requires the plan to submit their application to TDI. As a state licensed entity, the managed care plan is under the oversight of the insurance department related to solvency issues.

68. State laws regarding managed care patient protection rules and consumer complaints do not apply to a Medicare managed care plan. While originally, TDI processed Medicare managed care complaints through its HMO division, any complaints or calls are referred back to the plan. TDI does not track or maintain copies of Medicare managed care complaints. Since Medicare managed care has a direct impact on Medicare supplement insurance policies which are under the regulation of TDI, TDI frequently issues news releases and insurer directives as they relate to what is happening in the Medicare HMO market.

Note: The TDI, HICAP contract has enabled staff in Consumer Protection to monitor Medicare managed care penetration levels, capture issues related to these plans and to respond to consumer inquiries. Additionally, the HICAP coordinator at TDI maintains regular contact with CMS, managed care staff and as possible with staff at each plan. Local benefits counselors are encouraged to make contact with plans available in their area, by attending marketing meetings and by becoming familiar with the plan's benefits and provider networks.

69. **How a Medicare + Choice managed care plan covers the gaps in Medicare** Medicare plans herein referred to as HMOs agree to provide all Medicare approved services to Medicare beneficiaries that join the HMO. CMS pays the HMO a monthly fee for each Medicare beneficiary enrolled in the plan. Persons, who join the plan, may or may not pay a plan premium and only pay copayments when they access a service or provider. The copayments have usually been less than what the beneficiary would pay as coinsurance under Original Medicare. In addition, Medicare HMOs usually cover benefits like preventive care and prescriptions, services that Medicare does not cover. The added services may also have copayments. The beneficiary continues to pay the Medicare Part B monthly premium (\$54.00 in 2002), which is usually withheld from their Social Security monthly check.

70. Many of the remaining Medicare HMOs have significantly reduced or eliminated benefits beyond what Medicare covers. Additionally, most HMOs now require a monthly premium (that may not be less than a Medigap premium), deductibles of as much as \$350 for Medicare Part A, and higher copayments. A Medicare HMO may no longer be less in cost than a Medigap policy. For example, HMO copayments for radiation services are ranging from \$100 to \$350 per treatment. These costs would be considered coinsurance in Original Medicare and any Medicare Part B coinsurance is paid by any Medigap plan. Benefits counselors need to review how these terms are defined by the HMOs and what the amounts are in order to help a person compare costs between plans.

71. **How Medicare HMOs Work.** To join an HMO, the beneficiary must reside in the HMO's service area (usually a county, but in some cases by ZIP code), must have both Medicare Part A and Part B, and must not have End Stage Renal Disease (ERSD). If a beneficiary develops ESRD after enrolling in the HMO, coverage would continue and that person would have a right to continued coverage with another M+C plan should their plan decide to end coverage. An M+C plan can not exclude an otherwise eligible applicant because of pre-existing conditions other than ESRD. To find out if a Medicare HMO is available in a given area, call the toll-free numbers at either the Texas Department of Insurance (TDI) at 1-800-252-3439 or Medicare at 1-800-633-4227 or visit the Medicare website at www.medicare.gov.

72. To control costs the HMO contracts with health care providers to furnish all necessary services. These providers make up the HMO's "network." Generally, members must obtain services from providers in their HMO's network. Members choose a primary care physician (PCP) from the HMO's network list of participating doctors. The PCP either delivers or authorizes all of the member's care. This

means a member must have a referral from their PCP to see a specialist. In that a referral is needed from the primary care physician to see a specialist. In most cases, the specialist must also be in the HMO's network. Members who obtain medical care from providers not in the HMO's network or without a referral from their PCP may have to pay the full cost of the care they receive themselves. Exceptions are made for emergency care.

73. The two types of M+ C managed care plans available in Texas currently are:

- Health Maintenance Organization – A type of managed care plan that is run by an insurance company or corporation that contracts with a network of doctors, hospitals, and other health care providers. The HMO contracts with Medicare to provide all Medicare services to Medicare beneficiaries that join the plan. The HMO receives a set amount of money from Medicare for each member if the plan.
- Provider Sponsored Organization – A type of managed care plan that is run by the doctors and providers themselves, and not by an insurance company or corporation. The network of doctors, hospitals and other health care providers agree to provide all Medicare services for Medicare beneficiaries that join the plan. Like with an HMO, Medicare agrees to pay a set amount of money per month for each beneficiary that joins the plan.

74. **Out of pockets costs with a Medicare + Choice Managed Care Plan.** The beneficiary must continue paying the Medicare Part B premium, which usually is deducted from the beneficiary's Social Security check. Some M+C plans then charge an additional monthly premium, although some charge nothing. There is also a fixed copayment each time a medical service is provided. If the HMO plan covers prescription drugs, there will probably be a different set of copayments for generic versus brand name prescriptions. Some HMOs only cover prescriptions that are on their drug formulary. In addition, most HMOs set an annual dollar limit for added benefits. Most M+C plans approved for fiscal year 2002 for the first time included copayments for hospital admissions and for certain treatments that are significantly higher than the coinsurance amount in Original Medicare.

75. **Identifying Medicare M + C Benefits.** The HMOs that contract with Medicare can change benefits and copayments each year. The Medicare website allows consumers to compare benefits amounts, copayments and deductibles for HMOs in their area. To learn which providers are in an HMO's network, consumers must obtain an application packet from the HMO or may in some cases, visit the HMO's website. The Medicare website provides a toll free number for each HMO option available and may list a website address if one is available.

76. **More About How Medicare HMOs Work.** When a Medicare beneficiary joins an HMO, the beneficiary leaves Original Medicare. Medicare HMOs differ from Original Medicare in several ways, including:

- HMO withdrawals. Medicare HMOs decide each year whether to stay in or withdraw from the Medicare market. If an HMO withdraws from the market, its members are automatically returned to Original Medicare at the end of the fiscal year. Members may join another managed care plan, if one is available in their area. If another plan is not available, beneficiaries can consider purchasing a Medigap policy to cost the gaps in Original Medicare. When a Medicare HMO will withdraw from the market, it must notify its members in writing about options available through remaining M+C plans and/or their right to buy Medigap insurance plans A, B, C or F. If a member has not moved into another M+C plan by January 1, the beneficiary is automatically returned to Original Medicare. The right to buy a Medigap policy plans A, B, C, or F lasts for 63

days and requires that the companies sell the policy without regard to pre-existing conditions or wait periods.

- Words like "assignment"; "excess charge" and "Medicare approved rate" that apply to Original Medicare do not apply to HMOs. The application packet for an HMO and the member's "evidence of coverage," sometimes referred to as the member handbook, will include definitions and terms that apply to the HMO.
- HMOs pay only for emergency care and urgently needed care when the beneficiary is outside of the service area. This could be a problem if the member travels frequently. A member can be dropped from the HMO if he or she leaves the service area for 90 consecutive days.
- Although an HMO might offer prescription coverage, it does not mean that a member can get any brand name prescription they choose. HMOs have lists of prescriptions that they will cover. This list is called the HMO's "drug formulary." Upon request, the HMO must disclose whether a specific drug is on its formulary. The HMO must pre notify members about change to formulary, which can change during the year.
- Since health care in an HMO must be provided or authorized by a member's primary care physician (PCP), the member cannot see a specialist without a referral from the PCP. If a specialist is not available in the network, the HMO may refer the member to a specialist outside the network. The HMO would be responsible for covering the costs of the specialist.
- HMO members do not have to file claims when they receive care. The member is only responsible for paying the copayment amount. The provider, not the member, is responsible for collecting reimbursement from the HMO for the services.
- HMO members do not need other insurance to supplement their Medicare.

77. **Additional Benefits.** Some Medicare HMOs may provide more benefits than traditional Medicare. These could include free or low-cost preventive care, dental care, prescriptions, hearing aids and eyeglasses. The HMO may charge an additional premium for added benefits. Also, remember that HMOs can change their benefits each year when their contract with CMS is renewed. An HMO that offers an added benefit, such as prescription drug coverage, could later drop that benefit.

78. **How to get the most from an HMO.** To get the most from an HMO, members should:

- **Read the HMO plan booklet.** Tell consumers to keep the HMO telephone numbers handy (usually located on the back of their member card) and to learn how regular appointments, referrals and emergency care are handled.
- **Be clear about coverage for emergency care received at non-HMO facilities ("out-of-plan facilities").** An HMO must pay for emergency care wherever it is received. Members must make sure they understand how the HMO defines emergency care. Ultimately, however, the member is the judge of whether a situation is an emergency. The HMO must approve or deny requests from a treating doctor for services following emergency treatment and stabilization within one hour. The HMO should be notified as soon as possible that a member is receiving emergency care in an out-of-plan facility. Outside the service area, care for life-threatening conditions and other urgently needed care is covered. "Urgently needed care" will be defined in the member handbook.

- **Know how to file a quality of care, availability or access to care complaint.** Members should, first try to resolve any issues or concerns with their primary care physician. If the issue cannot be resolved at the doctor level, the member should file a written complaint with the HMO plan administrator or customer service representative. Recent trends show that network providers problems have included limited access to doctors, greater travel distances for specialists or other services and delayed appointment for referrals to specialists. While some of these issues can impact the quality of care, at times it may be necessary to address the issue from the perspective of access to care. HMOs are required to have adequate provider networks. Frequently, having the member or a benefit counselor question an action or asking for a review can change the response of the HMO. A member also has the right to change their PCP. Inpatient hospital complaints regarding services would be processed through the Peer Review Organization (PRO). In Texas, the PRO is the Texas Medical Foundation at 1-800-725-8315. Although the Texas Department of Insurance does not have authority over Medicare HMO complaints, the HICAP representative can usually assist the Benefit Counselors who have questions about complaints.
- **Know how to file an appeal.** Federal regulations require that Medicare HMOs provide appeals procedure for members. The member should ask the doctor to explain why a service was received or not received. If treatment was denied, find statements in the member handbook (evidence of coverage) that would lead the member to believe it should be covered. A denial of service outside the hospital setting would be filed directly with the HMO. If it is denied at that level it would be automatically send to the Center for Health Dispute Resolution (CHDR). CHDR is a national independent contractor that reviews all M+C appeals. CHDR must make a decision within 60 days, although there is an avenue for expedited review. Even if CHDR denies the appeal, they're maybe an opportunity for further review. Benefit counselors can seek the assistance of the TDI HICAP Coordinator as well as the Legal Hotline for Older Texans to assist members with an appeal.
- **Know how to get out of an HMO.** To withdraw (disenroll) from an HMO the member should notify the plan or the local Social Security office in writing. Before leaving an M+C plan, it is important that alternate coverage be secured. Beginning January 2002, there are new rules regarding changing Medicare plans. Where previously, someone could leave an M+C plan and return to Original Medicare, beneficiaries can now change between an M+C to Original Medicare, just once between January and June 2002. Additionally, managed care plans can close enrollment outside of the mandated annual open enrollment period (October through December.) There are special circumstances under which the above rules can be waived for a beneficiary. These special situations are outlined in a new CMS brochure titled, New Rules for Switching Medicare Health Plans. The brochure is available on the Medicare website.

Note: The new rule that locks a beneficiary into Original Medicare or an M+C plan is being reviewed by Congress and maybe repealed as it is being implemented.

- **Medicare HMO must have procedures for continued coverage of "special circumstance" patients.** If the HMO terminates its contract with a provider, the HMO must continue to pay the provider to treat the special circumstance patient for up to 90 days after the termination date. Special circumstances include acute or life-threatening conditions and terminal illness as determined by the treating physician.
- **Patient rights under a M+C plan.** Federal law requires that managed care plans inform their members about the grievance and appeals process in the member handbook. Additionally, the HMO uses patient surveys to monitor member satisfaction. These surveys are frequently mailed to the member's home. Beneficiaries are frequently confused and frustrated trying to navigate

within the HMO system. As advocates, benefits counselors are encouraged to establish contacts with M+C plans operating in their area. These contacts can frequently help to resolve a complaint on behalf of a client, who has attempted to follow procedures for a complaint or grievance to no avail. The TDI, HICAP coordinator can assist counselors to intervene in difficult cases or to expedite a complaint. It is important to document each contact made on behalf of a client as these may be indicators of patterns within a specific HMO or a system wide problem that needs to be changed.

79. Other information and resources regarding Medicare managed care plans.

To find out if a M+C Managed care plan is available and to review benefits and costs - Medicare website, Medicare Compare Interactive Program. Allows you to enter ZIP code or county. You can also call 1-800-MEDICARE give them the ZIP Code and ask them for the toll-free telephone for each plan available. You would then call each plan and ask for a prospective member packet.

To resolve a member's grievance or appeal – Contact the customer services representative using the toll-free telephone number located on the back of the member's membership card or review the member handbook.

CMS Reading Resources:

- *Medicare and You* - Annual publication that outlines M+C plans available are region and new changes to Medicare.
- *Choosing a Medicare Health Plan: A Guide for People with Medicare* – Worksheet type brochure that describes different M+C plans. Organized in a question and answer format, requires client to gather information that will help them make an informed choice on options by revealing the person's medical and lifestyle needs. Recommended as training overview on how to assist client's review their options.
- Medicare Health Plan Nonrenewal Fact Sheet – General overview on the Medicare HMO termination process and steps to follow.
- Your Medicare Rights and Protections – Outlines Medicare basic benefits and rights needed to better understand if a issue should be considered a justified denial or a complaint or grievance. Recommended as training overview to help benefits counselors research steps to follow to resolve a client's concern.

Other print resources and contacts – Publications and periodicals from the Medicare Rights Center. The MRC is a national non-profit organization devoted to advocacy on behalf of Medicare beneficiaries. A Medicare Survival Packet produced by this organization was provided to each Texas Area Agency on Aging. Additionally, a first year subscription to their bi-weekly fax periodical, Medicare Watch was purchased for each AAA. MRC serves as the state SHIP for the state of New York, making their information very timely to current issues related to Medicare.

Texas Department of Insurance – Although the Texas Department of Insurance does not have regulatory authority over Medicare managed care plans, the HICAP coordinator can assist with processing of complaints and M+C related concerns. The coordinator also has region and national contacts familiar with issues related to Medicare managed care plans. Contact the HICAP Coordinator at (512) 322-4340.

80. **MEDICARE+ CHOICE - Private Fee-for-Service Plan.** A private fee-for-service (PFFS) plan is another new option available to some Medicare beneficiaries. PFFS is different from original Medicare or a Medicare+Choice managed care plan. With a PFFS plan, the Centers for Medicare and Medicaid Services (CMS) contracts with a private insurance company that agrees to provide all Medicare approved services to Medicare beneficiaries who join the plan. The contract defines a geographic service area by county or ZIP code. Different from the managed care plan option, the PFFS plan allows beneficiaries to go to any doctor, hospital or provider, as long as the provider agrees to the terms and conditions for reimbursement outlined by the PFFS plan. A beneficiary who joins the PFFS plan is no longer in original Medicare and must follow the procedures and rules of the plan to receive their Medicare benefits. Members don't have a primary care physician to oversee their care, so they don't need a referral to go to a specialist.
81. CMS enters into a one-year contract with the PFFS contractor and approves the plan's benefits, premiums and any other out-of-pocket costs that will be passed on to persons that join the plan. CMS pre-pays a monthly fee for each beneficiary that enrolls in the PFFS. The PFFS plan assumes all claims processing to health providers that agree to Medicare approved services to members of the plan. The amount of reimbursement to providers maybe different from the Medicare approved amounts under original Medicare. Additionally, the rules allow for PFFS plans to balance bill members. Currently there is only one insurance company; Sterling Life Insurance Company that is approved to offer the PFFS plan. The plan is referred to as Sterling Option 1.
82. **Note:** Sterling Option 1 is available in most of Texas but enrollment has not been significant. The plan is in its second year of operation in Texas, and recently withdrew from some counties that seemed to have higher number of applicants. This insurance company also obtained a license to sell Medicare Supplement insurance in Texas at the same time that it began selling the PFFS plan. To find out if this Medicare+Choice option is available in an area, call the Medicare toll-free number 24 hours a day at 1-800-633-4227 or use the interactive Medicare website, www.medicare.gov/MPHcompare/home.
83. **Regulatory authority and sources of law.** The Balanced Budget Act of 1997 authorized the US Department of Health and Human Services, CMS to enter into contracts with insurance companies. As an M+C option, the PFFS must develop processes for quality care improvement, appeals and grievances. The plan is subject to the external quality monitoring by the same independent CMS contractors and the national agent for reconsideration of denials that monitors the M+C managed care plans. The CMS region office is responsible for state monitoring of the PFFS plan and the review of marketing and advertising materials is approved at the CMS, Central office.
84. Similar to the M+C managed care plans, the PFFS plan must meet federal contracting requirements and also be a state-licensed entity. The Texas Department of Insurance does not have a formal role in the review of the PFFS application process, although the company offering the plan must meet licensing requirements as a company selling insurance in Texas. Beneficiary complaints, grievances or appeals regarding the PFFS plan must be submitted through the process outlined by the PFFS plan. Issues related to unduly delayed payment of claims can be directed to the Texas Department of Insurance, as these might be indicators of solvency issues which are under the authority of TDI.
85. **Note:** The TDI HICAP coordinator maintains contacts and information about the PFFS plan and can therefore serve as a resource to resolving issues related to this plan.
86. **How the Medicare Private Fee-for-Service (PFFS) cover the gaps in Medicare.** The PFFS plans agree to provide all Medicare approved services to beneficiaries that join the plan. The member will

pay a monthly premium (\$78 in 2002) to the PFFS plan. The premium is different from the Medicare Part B monthly premium, which the beneficiary continues to pay directly to Medicare.

87. The beneficiary will pay Medicare Part A and Part B copayments (fixed amounts dependent on the service received) and coinsurance (a percentage of the cost for certain services.) In the PFFS plan these costs are applied differently than in original Medicare. For example, “Inpatient Care” in original Medicare, applies a deductible (\$819 in 2002) per benefit period. In the PFFS plan the same “Inpatient Care” applies a per admission copayment (\$350 in 2002) without regard to benefit period. Additionally, the PFFS plan requires pre-notification of any inpatient admission. Failure to pre-notify will increase the copayment amount by \$50 for each day until notice has been given to the plan. There is a \$500 maximum limit for the penalty payment.
88. The coinsurance in original Medicare is 20 percent of the Medicare-approved cost. In the PFFS plan the coinsurance can range from 20 to 70 percent of the PFFS approved amount. Like with the copayment, there is an increased amount that can be applied for failure to notify the plan in advance of receiving service.
89. **How does the Medicare PFFS Plan Work?** To join the PFFS plan, a person must reside in the plans service area, have both Medicare Part A and Part B, and cannot have End-Stage Renal Disease (ESRD). The PFFS plan’s contract with CMS is for one year. Each year, the PFFS plan decides whether to stay in or leave Medicare. If the plan leaves Medicare, members must either return to original Medicare or join another M+C plan. The PFFS plan is available in rural areas that most Medicare managed care plans would not traditionally serve. The monthly premium, copayments and coinsurance change at the start of each year.
90. The PFFS plan cannot exclude an otherwise eligible applicant because of pre-existing conditions, other than ESRD.
91. Enrollees can obtain services from any provider that accepts the plan's terms and conditions. The PFFS plan is responsible for payment directly to the physician or provider. The beneficiary pays a set copayment to the provider. Providers are reimbursed at different rates dependent on whether they decide to work with the plan as a contracted provider (also referred to as a “deemed” provider or provide a service as a “non-contracted” provider. Responsibility to identify providers willing to accept the plan currently falls to the member. The member is also liable for paying any non-covered Medicare services received from providers. The PFFS plan uses prior notification rules as a way to control cost. The beneficiary will be charged a higher copayment or coinsurance if they fail to get prior approval before receiving certain services. In some instances if the PFFS plan determines that a service received was not "medically necessary," they deny payment. An enrollee can appeal the denial.
92. **Identifying the out-of-pocket costs for joining the PFFS option.** The beneficiary pays a fixed monthly premium. In addition there are different copayment amounts based on the service received. A member could pay an even higher copayment amount if prior notification rules are not complied with.
93. The PFFS plan could be more costly than other Medicare options for certain beneficiaries. Persons that require frequent hospitalization (\$350 copayment per admission) or use durable medical equipment, outpatient mental health services or home health services (50 percent coinsurance) would pay significantly higher out-of-pocket cost than some of the other Medicare options. A screening questionnaire that identifies all other insurance that the beneficiary possesses as well as medical services needed would help a person decide if this option is appropriate for their situation.

94. In general this plan maybe a suitable option for someone who is fairly healthy and does not use the higher cost services such as hospitalization and durable equipment. The premium for the PFFS plan is now comparable to the premium for a Medicare supplement Plan A for someone who just turned 65 years old. A more important aspect of this plan is assuring that the doctors and other health providers become familiar with how the plan reimburses providers and that those providers are willing to work with the PFFS plan.
95. **Identifying Medicare PFFS Benefits.** The PFFS plan will cover all required Medicare services that are provided as medically necessary. This includes new preventive health exams. The only benefit enhancements beyond what Medicare covers is reimbursement for emergency care outside the U.S. and increased inpatient hospital days beyond what Medicare covers.
96. The member must pay an annual deductible before the plan pays for emergency care. In addition there is a coinsurance of 20 percent that the member must also pay. There is a maximum annual limit for emergency care while out of the United States.
97. Information about the Sterling Option 1 PFFS plan is available by calling 1-888-858-8572. The plan also offers a web site address listed in the resources section at the end of this section.
98. The PFFS plan's benefits and costs are also available on the Medicare compare web site. If a person resides in a PFFS area, the PFFS plan will be included in the comparison of plans.
99. **More About How Medicare PFFS Works.** When a beneficiary joins the PFFS plan, he or she leaves original Medicare. Following are aspects of the PFFS plan that are different from original Medicare:
- Eligibility, enrollment and disenrollment guidelines in the PFFS plan are the same as those in M+C managed care plans. Effective January 2002, new rules apply to how to change from M+C plans to original Medicare.
 - Since doctors and other providers can chose not to accept the plan's terms of payment, members should tell their provider before a service is rendered that they are in the PFFS plan. If a particular physician or provider does not accept the plan, the member will have to find another provider.
 - Like in Medicare managed care plans; it is important that members become familiar with the plan's member handbook that defines terms unique to the plan and outlines procedures for accessing services. Some members could be liable for paying higher costs if they frequently need services that have higher copayments, or if they fail to comply with prior notification rules or can not find providers that accept the PFFS plan.
 - Persons that require treatment from specialists or other providers should make certain that the specialist and facility s/he uses is also willing to accept the PFFS plan.
 - Members in a PFFS plan may not have to file claims when they receive care. The legislation that authorized the PFFS plan allows plans the option to require enrollees to pay providers in advance and then to submit claims to the plan for reimbursement back to the member. The member is responsible for paying the copayment amount. Providers in the current CMS approved PFFS plans are not allowed to bill the member more than the fixed copayment amount. Future PFFS plans could allow "balance billing" meaning that the beneficiary could be asked to pay more than the copayment.

- PFFS plan members cannot be in another Medicare + Choice plan or have a Medigap policy while they are in the PFFS plan. If the member has group insurance, they will want to review how their group plan will coordinate with the PFFS plan.

100. How to get the Most from the PFFS Plan. To get the most from the PFFS plan, members should:

- **Do homework as with any new program.** Find out by talking to friends, physicians and providers if the PFFS plan is being accepted in your area. If no one is familiar with the plan, ask the plan representatives to identify which providers in your area have agreed to accept the plan.
- **Be clear about coverage for emergency and inpatient hospital care.** The PFFS plan cannot restrict enrollees to use a provider network or require a referral to see specialists. The plan does require prior notification defined as "advance coverage decision" before certain services are accessed. The plan can charge a higher copayment for not receiving prior notification or could deny coverage as not "medically necessary".
- **Know how to file a quality of care, or access to care complaint.** PFFS enrollees have the same grievance and appeals rights as Medicare managed care plans. The member handbook that the plan must provide each enrollee will outline and identify how to file a complaint. Medicare + Choice options do not follow procedures used in original Medicare. Providers can file complaints directly to the PFFS plan for non-payment of claims. The provider can not collect reimbursement from the member unless the member continues to see a provider that will not contract with the plan. Although the Texas Department of Insurance does not have authority over the PFFS plan any undue delay in payment to providers for what would otherwise be an approved Medicare claim, may be filed with TDI as nonpayment could be an indication of solvency problems.
- **Know how to appeal decisions.** The PFFS plan must follow the appeals process for all M+C plans. This process which has three components is detailed in the member handbook. The categories of appeals are: regular appeal for denial of service or payment; expedited appeal which require a determination within 72 hours; and hospital-related appeal which is handled by the state's Peer Review Organization (PRO). If the PFFS plan denies an appeal, the PFFS plan must forward the denial for review to the Center for Health Dispute Resolution (CHDR). CHDR is a national independent contractor that reviews all M+C appeals. CHDR must make a decision within 60 days, although there is an avenue for expedited review. Even if CHDR denies the appeal, there maybe an opportunity for further review. Benefit counselors can seek the assistance of the TDI HICAP Coordinator as well as the Legal Hotline for Older Texans to assist members with an appeal.
- **Know how to get out of the PFFS.** To withdraw (disenroll) from the PFFS plan the member must notify the plan or the local Social Security office in writing. Before leaving an M+C plan, it is important that alternate coverage be secured. Beginning January 2002, there are new rules regarding changing Medicare plans. Where previously, someone could leave an M+C plan and return to original Medicare, beneficiaries can now change between an M+C to original Medicare, just once between January and June 2002. There are special circumstances under which the above rules can be waived for a beneficiary. These special situations are outlined in a new CMS brochure titled, *New Rules for Switching Medicare Health Plans*. The brochure is available on the Medicare website.
- **Note:** The insurance company that offers the PFFS plan also sells Medicare supplement insurance policy. The company has promoted the option to begin in the PFFS plan with the understanding that if the beneficiary ever wanted to get out of the PFFS plan they would have an

automatic right to buy a Medigap policy from this company. New rules about switching from Original Medicare to M+C Medicare would not allow for a change after June 2002.

101. More Information and Resources to the PFFS Plan. To find out if the private fee-for-service plan is available and details about the costs and benefits visit the Medicare Compare Interactive website. More limited information can be obtained by calling the Medicare toll free telephone.

CMS Reading Resources

- *Your Guide to Private Fee-for-Service Plans* - 24-page brochure available for downloading on the Internet. This brochure is a source for general information about the concept of the PFFS plan. Especially read about the requirement that PFFS plans offer a care coordinator program. The current Sterling Option 1 PFFS member handbook should be used to address questions about their plan. Good source for definitions for terms relevant to the PFFS plan. A Spanish translation is also available.
- *Medicare Health Plan Nonrenewal Fact Sheet* – General overview on the Medicare HMO termination process and steps to follow.
- *Your Medicare Rights and Protections* – Outlines Medicare basic benefits and rights needed to better understand if a issue should be considered a justified denial or a complaint or grievance.
- Recommended as training overview to help benefits counselors research steps to follow to resolve a client's concern.

Other print resources and contacts

- Publications and periodicals from the Medicare Rights Center. The MRC is a national non-profit organization devoted to advocacy on behalf of Medicare beneficiaries. A Medicare Survival Packet produced by this organization was provided to each Texas Area Agency on Aging. Additionally, a first year subscription to their bi-weekly fax periodical, Medicare Watch was purchased for each AAA. MRC serves as the state SHIP for the state of New York, making their information very timely to current issues related to Medicare.
- Texas Department of Insurance – Although the Texas Department of Insurance does not have regulatory authority over Medicare managed care plans, the HICAP coordinator can assist with processing of complaints and M+C related concerns. The coordinator also has region and national contacts familiar with issues related to Medicare managed care plans. Contact the HICAP Coordinator at (512) 322-4340.