# Medicare

## *Worksheet for Comparing Medicare Health Plans*


HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Medicare & You

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Congress passed a law in 1997 that made many changes in the Medicare program. The law includes a section called Medicare + Choice, which creates new health plan options. The new health plan options are explained in *Medicare & You*. All beneficiaries will receive a copy of *Medicare & You* by mail.

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 the 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 from 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.

**You can get up-to-date information about the Medicare health plans available in your area:**

- On the Internet at **www.medicare.gov**. Your local library or senior center may be able to help you find this information on their computers.

- By using the automated Medicare Special Information number (1–800–318–2596 or TTY: 1–877–486–2048).

- By calling the State Health Insurance Assistance Program (SHIP) in your area. The number for your SHIP will be listed in your copy of *Medicare & You* (which beneficiaries will receive in November of 1998), or can be found on the Internet at **www.medicare.gov**.

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 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.**

**Write the plan names in the blocks below.**

| Call the Plan.<br>Does the plan . . . | Plan: | Plan: | Plan: |
|---|---|---|---|
| Charge a premium in addition to the Medicare Part B premium? | | | |
| Charge copayments for doctor visits? | | | |
| Pay for prescriptions? How much? | | | |
| Charge more if I use a doctor or hospital outside the plan? How much? | | | |
| Have maximum amounts it will pay for different services? | | | |
| Set limits on what doctors and hospitals charge you? | | | |
| Charge a deductible or coinsurance for inpatient hospital services, home health, or skilled nursing facility services? | | | |

In the Original Medicare Plan and the Original Medicare Plan with a Supplemental Insurance Policy, you may use any provider who accepts Medicare. Private Fee-for-Service Plans provide similar choice. In a Medicare 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, and ask . . . | Plan: | Plan: | Plan: |
|---|---|---|---|
| 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 he/she 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's 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, 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: | Plan: | Plan: |
|---|---|---|---|
| Do I have to file claims myself? | | | |

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.<br><br>Does the plan cover/provide... | Plan: | Plan: | Plan: |
|---|---|---|---|
| Routine physicals? | | | |
| Eye exams, glasses, contacts? | | | |
| Hearing exams and hearing aids? | | | |
| Dental exams/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, care giver 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 may be interested in: | | | |

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: | Plan: | Plan: |
|---|---|---|---|
| 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 it pays for to those on a list of drugs (called a 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: | Plan: | Plan: |
|---|---|---|---|
| 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? | | | |

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 a Medicare health plan.

**1) Accreditation.** This is an additional seal of approval by a private independent non-profit group, which evaluates a plan and gives it an official status based on that evaluation. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Healthcare Commission.

**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. In late 1998, some of these reports will be available on the Internet at www.medicare.gov.

| Ask . . . | Plan: | Plan: | Plan: |
|---|---|---|---|
| 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? (You can get some of this information on the Internet at www.medicare.gov in late 1998.) | | | |

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 things 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 decision, special rules apply and you are entitled to a decision within 72 hours.

| Call the plan, and ask . . . | Plan: | Plan: | Plan: |
|---|---|---|---|
| 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 Here: | Plan: | Plan: | Plan: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**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 to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. They include Health Maintenance Organizations (HMOs), HMOs with Point of Service Options, Provider Sponsored Organizations, and Preferred Provider Organizations.

**Medical Emergency**—Includes severe pain, an injury, sudden illness, or suddenly 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 your medical bills. Medicare also pays the premium for the health policy.

**Original Medicare Plan**—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.

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