

**A COMPLETE GUIDE
To
HEALTH CARE COVERAGE
FOR
OLDER
NEW YORKERS**

2010

CHECK IT OUT!



Prepared by
The New York City Department for the Aging
Health Insurance Information, Counseling and Assistance Program (HIICAP)
New York City Department for the Aging
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MICHAEL R. BLOOMBERG

Mayor

City of New York



Lilliam Barrios-Paoli

Commissioner

NYC Department for the Aging

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This guide has been developed by the New York City Department for the Aging's Health Insurance Information, Counseling and Assistance Program (HIICAP) to help older New Yorkers better understand the health care coverage options currently available in New York City. The topics range from Medicare, Medicare Part D, Medicare health plans, Medicaid, and Medicare Savings Programs, to "Medigap" insurance and Long-Term Care Insurance. The information detailed here is current for the year 2010. Use it in good health!

HIICAP is New York's source for free, current and impartial information about health care coverage for older people. The HIICAP Helpline can assist you in getting your questions answered. Please call 311 and ask for HIICAP to speak with one of our trained counselors.

We have HIICAP counselors available to meet with you in person at one of our counseling sites or over the telephone. Simply call our helpline for a referral to the counselor nearest you.

Please note that inclusion of specific health care benefit programs does not necessarily constitute endorsement of these programs on the part of the New York City Department for the Aging.

Dial 311 for information regarding this and other City services.

www.nyc.gov/aging
<http://hiicap.state.ny.us>

MEDICARE

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people and people with kidney failure. It has four components:

- Hospital Insurance (Part A)
- Medical Insurance (Part B)
- Medicare Advantage plans (Part C - HMO, PPO, Special Needs Plans (SNP) and Private Fee-For Service (PFFS) coverage). Medicare Advantage plans provide hospital and medical coverage. If someone joins a Medicare Advantage plan, they will have Part A and Part B coverage through that private plan, not through "original Medicare."
- Prescription Drug Coverage (Part D). Medicare Advantage enrollees who want drug coverage must get that coverage through their plan. Enrollees in "original Medicare" who want drug coverage sign up for a plan through a standalone Part D plan.

Who is Eligible for Medicare?

You are eligible for Medicare if you or your spouse worked for at least 10 years, paid Medicare taxes, and you are 65 years old or older, and a citizen or permanent resident of the United States. People under age 65 may qualify for coverage after receiving Social Security Disability Insurance for 24 months; people with Amyotrophic Lateral Sclerosis (ALS) qualify the first month they receive SSDI. People with end stage renal disease (ESRD) can qualify for Medicare, regardless of age. A worker, as well as a worker's spouse or children may be eligible for Medicare, based on the worker's work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare. If you have questions about your eligibility for Medicare, or if you want to apply for Medicare, call the Social Security Administration at 1-800-772-1213 (1-800-325-0778 TTY). You can learn more about applying for Medicare at Social Security Online, www.socialsecurity.gov.

How Do I Enroll in Medicare?

Automatic Enrollment: If you are already getting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about three months before your 65th birthday. If you receive Social Security Disability benefits, you will automatically get a Medicare card in the mail after you have received Social Security Disability benefits for 24 consecutive months.

Applying for Medicare: If you are not receiving Social Security or Railroad Retirement benefits when you turn 65, you have a seven-month Initial Enrollment Period (IEP) in which to enroll in Medicare. You can enroll by contacting the Social Security Administration (SSA) three months before you turn 65, as well as the month in which

you turn 65 and the three months that follow.

If you do not enroll during this seven-month period, you will have to wait to enroll during the next general enrollment period which is January 1 to March 31 of each year, but Part B coverage will not start until July. If you do not enroll during the initial enrollment period and do not have other coverage through an active employer of you or your spouse, you will face a higher premium as a penalty for late enrollment. The penalty for late enrollment is 10% for every 12 months of non-enrollment in Part B.

Actively Employed and Medicare Eligible: If you or your spouse are actively employed and have health insurance through the employer, you may not need to enroll in Medicare Part B when you first become eligible; contact the employer as to whether you are required to enroll in Part B. You may wish to enroll in Part A regardless because there is no premium for this coverage. Refer to the section on Medicare as Secondary Payer (page 18) for more information.

Medicare Part A Benefits

Medicare Part A covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

Medicare Advantage enrollees get their Part A benefits through their plan and cannot submit bills to Medicare.

Inpatient Hospital Care: Medicare pays for up to 90 days of medically necessary care in either a Medicare-certified general or psychiatric hospital during a benefit period. A **benefit period** starts when you are admitted to the hospital and continues until you have been out of the hospital and skilled nursing facility for 60 consecutive days. After one benefit period has ended, another one will start whenever you next receive inpatient hospital care. Medicare beneficiaries have 60 lifetime reserve days after day 90 of each benefit period.

Medicare will pay for a lifetime maximum of 190 days of inpatient psychiatric care provided in a psychiatric hospital. After 190 days have been used, Medicare will pay for more inpatient psychiatric care only in a general hospital.

Medicare Part A helps pay for a semi-private room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests and X-rays. You are also covered for use of the operating and recovery rooms, mental health services, intensive care and coronary care units, and all other medically necessary services and supplies.

Part A Cost Sharing - 2010:

- Deductible: \$1,100 per benefit period
- Days 61-90 of an inpatient stay: \$275per day
- Lifetime Reserve Days : \$550per day

Skilled Nursing Facility Care: If after being discharged from the hospital, you need to go to a skilled nursing facility, Medicare will help pay for your care for up to 100 days in a benefit period. Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid for by Medicare except for a daily co-payment amount of \$137.50 in 2010. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Home Health Care: If you are homebound and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services. Medicare Part A pays the entire bill for covered services for as long as they are medically reasonable and necessary. The services may be provided on a part-time or intermittent basis, not full-time. Coverage is provided for skilled care, including skilled nursing care, physical, occupational, and speech therapy. If you are receiving skilled care, you may also qualify for other services, such as a home health aide and medical social workers.

Hospice Care: If you are terminally ill, you can elect to receive hospice care rather than regular Medicare benefits. Hospice care emphasizes providing comfort and relief from pain. The care can be at home or as an inpatient, and includes many services usually not covered by Medicare, such as homemaker services, counseling, and certain prescription drugs.

Medicare Part B Benefits

Part B of Medicare pays for a wide range of medical services and supplies, but most important is that it helps pay for doctor bills. The medically necessary services of a doctor are covered whether the care is at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also helps pay for:

- Outpatient hospital services
- Outpatient mental health care
- Blood, after the first 3 pints
- Ambulance transportation
- Physical, speech & occupational therapy
- Preventive & Screening tests
- Flu, pneumonia & hepatitis vaccines
- Injectibles
- Artificial prostheses
- X-rays & lab tests
- Durable medical equipment
- Medical supplies

Medicare Advantage enrollees get their Part B benefits through their plan and cannot submit bills to Medicare.

What Do You Pay Under Part B?

You are responsible for paying the annual Part B deductible. After meeting the deductible, Medicare pays for 80% of Medicare-approved charges. You are responsible for paying the other 20% which Medicare does not cover. When receiving outpatient mental health services, you are responsible for a co-insurance of 45% of the cost under Part B (as opposed to the 20% for all other medical services). Starting in 2010, Medicare is increasing the percentage it will pay for mental health services to 55%; by 2014, mental health services will be paid at 80%, similar to other Part B covered services.

Medicare will cover physical and speech therapy services up to \$1,860 per year and occupational services up to \$1,860 per year in 2010. There are certain exceptions which allow the cap to be extended. In addition, if therapy services are received in an outpatient hospital setting there is no cap; the cap only applies to services received in a private office or a patient's home (if not receiving Medicare covered home health care).

Medicare Supplement (Medigap) Insurance helps Medicare beneficiaries pay their share of the costs not covered by Medicare. These policies fill in the "gaps" of Medicare's reimbursement, but only for the approved services under Medicare coverage. See page 10 for information on Medigap policies.

Medicare Part B Cost Sharing – 2010

- Monthly Premium: \$110.50 (Individuals and couples with annual incomes over \$85,000 and \$170,000, respectively, will be responsible for higher premiums.)
- Annual Deductible: \$155

Social Security COLA and the Medicare Part B Premium

There is no Social Security Cost of Living Adjustment in 2010, meaning that those collecting Social Security Retirement, Survivors and Disability Insurance benefits will receive the same monthly benefit in 2010 as they did in 2009. Due to a "hold harmless" provision, Social Security recipients who paid \$96.40 for the Part B Premium in 2009 will continue to pay \$96.40 in 2010, rather than \$110.50. Those who will pay a higher Part B premium in 2010 include:

- Those new to Medicare Part B in 2010.
- Medicare beneficiaries who are not also collecting Social Security benefits.
- Beneficiaries who are subject to higher Part B premiums because their incomes are over \$85,000 for an individual/\$170,000 for married couples.
- Medicare Savings Program (MSP) beneficiaries. The MSP will continue to pay the higher Part B premium, but if the individual loses MSP status, he/she will have to pay the higher premium.

- Co-Insurance: 20%; 45% mental health

Assignment and Limiting Charge

There are two ways that doctors can participate in Medicare – they can “*accept assignment*” or “*not accept assignment*” – this can effect how much you are responsible for paying for their services. If your doctor *accepts assignment*, he or she will accept the amount Medicare approves for a particular service and will not charge you more than the 20% co-insurance. If the doctor *does not accept assignment*, the charges are subject to a “Limiting Charge,” which is an additional charge over the Medicare-approved amount. In New York State, the Limiting Charge is 5%, except for office visits and home visits, for which the Limiting Charge is 15 percent.

Private Contracting - Medicare “Opt Out”

Medicare providers have the right to officially “opt out” of Medicare for a two-year period and enter into a private written contract with any Medicare patient who seeks their treatment. The doctor will set a fee for each specific service and the patient agrees to pay the costs understanding that Medicare will not pay that doctor or reimburse the patient. A Medicare supplement policy or “Medigap” will not pay any of these costs either. The Medicare beneficiary is still covered by Medicare for services provided by other participating doctors and diagnosticians. “Opting Out” is different from providers who do not accept Medicare Assignment where the set fees and reimbursements are still controlled by Medicare. At this point, relatively few doctors have opted out of Medicare in New York State.

Advance Beneficiary Notice of Noncoverage

There are some health care services that Medicare will not pay for and the beneficiary has the right to understand the reasons why before the services are rendered. The health care provider must provide, in writing, the “Advance Beneficiary Notice of Noncoverage (ABN)” indicating the service that they believe Medicare will not pay for. The form must contain the service in question; the date of the service; a specific reason why the service may not be paid for by Medicare; and a place for the beneficiary to sign as proof that they understand and accept responsibility to pay for the service.

Medicare Summary Notice

For assigned claims, a Medicare Summary Notice (MSN) will be mailed quarterly to each Medicare beneficiary for whom a Part A and/or Part B claim was submitted by a provider. For unassigned claims, a MSN will be mailed as the claims are processed, along with a check to the beneficiary, if the beneficiary has pre-paid for the service. Beneficiaries will be able to utilize the MSN for reimbursement from a Medigap policy. The MSN contains information on how you can appeal Medicare claim denials.

Medicare Preventive Services

Medicare provides coverage for the following preventive services to help you stay healthy:

NEW: Beginning in 2011, Medicare will cover all preventive services at 100%, not subject to the Part B deductible and/or 20% coinsurance. In addition, Medicare will add coverage for an annual wellness visit.

| | |
|-----------------------------|---|
| Mammogram Screening | One baseline mammogram is covered between ages 35 and 39. All women with Medicare, aged 40 and older, are provided with coverage for a screening mammogram every 12 months. A diagnostic mammogram is covered at any time there are symptoms of breast cancer. The screening mammogram is subject to the 20% co-insurance but not subject to the Part B deductible. The diagnostic mammogram is subject to the Part B deductible and 20% co-insurance. |
| Pap Test and Pelvic Exam | A pap test, pelvic exam and clinical breast exam are covered every 24 months, or once every 12 months for women at higher risk for cervical or vaginal cancer. All women with Medicare are covered. No payment is due for the Pap test and 20% of the Medicare-approved amount is due for pelvic & breast exams without a Part B deductible. |
| Colorectal Cancer Screening | <p><u>Fecal Occult Blood Test</u>: covered once every 12 months and there is no payment due for this test.</p> <p><u>Flexible Sigmoidoscopy</u>: covered once every 48 months and you pay 20% of the Medicare-approved amount.</p> <p><u>Colonoscopy</u>: covered once every 24 months if you are at higher risk for colon cancer. If you are not at higher risk it is covered once every 10 years but not within 48 months of a screening flexible sigmoidoscopy. You pay 20% of the Medicare-approved amount.</p> <p><u>Barium Enema</u>: this can be substituted for a flexible sigmoidoscopy or colonoscopy; and you pay 20% of the Medicare-approved amount.</p> |
| Diabetes Services | Diabetes <u>screenings</u> for those at higher risk. Coverage for glucose monitors, lancets, test strips and diabetes self-management training for both insulin and non-insulin dependent of those diagnosed with diabetes. You pay 20% of the Medicare-approved amount after the Part B deductible. |
| Bone Mass Measurements | Procedures to identify bone loss, or determine bone density are covered every 24 months. Women at risk for osteoporosis or who are receiving osteoporosis drug therapy and persons with spine abnormalities will qualify for these procedures. You pay 20% of the Medicare-approved amount after the Part B deductible. |
| Vaccinations/Shots | <p><u>Flu</u>: covered once per year in Fall or Winter. No payment is due for this service.</p> <p><u>Pneumonia</u>: Prevents pneumococcal pneumonia. Usually only needed once in a lifetime. No payment is due for this service.</p> <p><u>Hepatitis B – if at high or intermediate risk</u>. You pay 20% of the Medicare-approved amount after the Part B deductible.</p> |
| Glaucoma Screening | People at high risk for glaucoma, including people with diabetes or a family history of glaucoma, are covered once every 12 months. You pay 20% of the Medicare-approved amount after the Part B deductible. |
| Prostate Cancer Tests | <p><u>Digital Rectal Examination</u>: covered once every 12 months for men aged 50 and older. You pay 20% of the Medicare-approved amount after the Part B deductible.</p> <p><u>Prostate Specified Antigen (PSA) blood screening test</u>: covered once every 12 months for men aged 50 and older. There is no payment due for this service.</p> |

| | |
|--------------------|--|
| Physical Exam | One routine physical exam will be covered during the first twelve months of Medicare enrollment. You pay 20% of the Medicare-approved amount. |
| HIV Screening Test | NEW benefit effective December 8, 2009, covered once every 12 months for any beneficiary who requests test and there is no payment due for this service. |

MEDICARE SUPPLEMENT INSURANCE (Medigap)

This information reflects changes to Medigap effective June 1, 2010.

What Is A Medigap Policy?

Medicare Supplement Insurance (Medigap) is specifically designed to fill the gaps in Medicare coverage. Regulated by federal and state laws, the policies can be purchased only by Medicare beneficiaries from a private company. You must have Medicare Parts A and B to purchase a Medigap policy.

Why Do I Need A Medigap Policy?

A Medigap policy offers reimbursement for out-of-pocket health service costs not covered by Medicare, which are the beneficiary's share of costs. For example, a Medigap policy might cover the Part A deductible, the Part B outpatient co-insurance of 20% of allowed charges, and the mental health co-insurance of 45% of allowed charges, and other costs. *Note that some plans only cover a percentage of these costs, while other plans cover them in full.* Medicare Advantage plan enrollees should not enroll in a Medigap plan, as this would duplicate coverage they have through their Medicare Advantage plan.

What Medigap Policies Are Available?

There are ten standard Medigap policies available in the United States, designated "A" through "N". Effective June 1, 2010, plans E, H, I and J will no longer be offered to new enrollees. Each of the policies has the basic benefit package (which cannot be changed by adding or subtracting the provisions), plus a combination of additional benefits. Older Medigap policies from before the 1992 standardization are still in effect, but cannot be offered to new buyers. Individuals with an older policy can switch to a new, standard policy, but would not be allowed to go back to the old policy. Some of the older policies may provide better coverage, especially for extended skilled nursing care. Additionally, individuals with Medigap plans E, H, I and J can maintain their existing coverage after June 1, 2010, but may wish to compare benefits with the premium cost to determine whether their plan remains cost effective.

When can I Enroll in a Medigap Policy?

In New York State, you can purchase a Medigap policy at any time when you are enrolled in Medicare. You are guaranteed the opportunity to purchase a policy even if you are Medicare-eligible due to medical disability and are under age 65.

When Can I Switch Medigap Policies?

In New York State, you can switch the company from which you get the Medigap policy, as well as the type of Medigap policy, at any time. Some companies require you to remain in a certain plan for a period of time before switching to a different plan that they offer. However, you can still get the desired plan from a different company that offers that plan.

How Do I Choose A Medigap Policy?

Since plans A through N are standardized, you first need to decide the level of coverage

you need. Once you establish which plan's set of benefits is right for you, you can compare the premium, service and reputation of the insurance companies. Most Medigap insurers have linked their computers with the computers at Medicare, so that your claims can be processed without additional paperwork ("electronic crossover"). In addition, companies can bill the premium monthly, quarterly or annually; your preference may be for a particular payment schedule.

How Am I Protected?

All standard Medigap policies sold today are guaranteed renewable. The insurance company cannot refuse to renew the policy unless you do not pay the premiums or you made misrepresentations on the application. Federal law prohibits an insurance company or salesperson from selling you a second Medigap policy that duplicates coverage of one you already have, thus protecting you from pressure to buy more coverage than you need. You can switch Medigap policies whenever you need a different level of coverage. When your health needs are greater, you can arrange to purchase a Plan F, for example, if you find plan B is too limited. The new Medigap policy would replace the previous one. **DO NOT CANCEL THE OLD POLICY UNTIL THE NEW ONE IS IN EFFECT.**

How Are Premiums Determined?

In New York State, you are protected by "community rating." The premium set by an insurance company for one of its standard Medigap policies is required to be the same without regard to age, gender or health condition. That means that the premium for Plan C from one insurance company will be the same for a woman, aged 72 in poor health as it will be for a man, aged 81, in good health. A chart of the ten standard plans follows the description of the plans. The insurance companies and their premiums for NYC Medicare beneficiaries can be found on page 19.

When Will My Coverage Start if I Have a Pre-Existing Health Condition?

The maximum period that a Medigap policy's coverage can be denied for a pre-existing health condition is the first six months of the new policy and only for those claims that are directly related to that health problem. A pre-existing condition is a condition for which medical advice was given, or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. You may qualify for **immediate** coverage for a pre-existing health condition (1) if you buy a policy during the open enrollment period after turning 65 or (2) if you were covered under a previous health plan for at least six months without an interruption of more than 63 days. If your previous health plan coverage was less than six months, your new Medigap policy must credit you for the number of months you had coverage. Some policies have shorter or no waiting periods for pre-existing conditions.

What Paperwork Will I Receive From My Medigap Insurer?

A Medigap insurance company is required to send you an Explanation of Benefits to document that it paid its portion of your claims for your health benefits. Combined with the Medicare Summary Notice (MSN) which you receive from Medicare, you will have the total information about how your health care claim was processed.

How Can I Get Help In Choosing A Medigap Policy?

Trained HIICAP counselors have current information on Medigap policies and can assist you in determining your needs. They will not make the choice for you, but they will

give you the specific information you need to decide.

How Does Medicare Part D Interact with Medigap Policies?

No new Medigap policies offer drug coverage. There is no interaction between newer Medigap policies and Part D.

STANDARD MEDIGAP PLANS

Below are the ten standard plans, Plans A–N, and the benefits provided by each:

PLAN A (the basic policy) consists of these **basic benefits**

- Coverage for the Part A coinsurance amount (\$275 per day in 2010) for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount (\$550 per day in 2010) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 45% of approved charges for outpatient mental health services), after the annual deductible is met (\$155 in 2010).
- Coverage for Medicare Part A hospice care cost-sharing.

PLAN B includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible (\$1,100 per benefit period in 2010).

PLAN C includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount (\$137.50 per day for days 21 through 100 per benefit period in 2010).
- Coverage of the Medicare Part B deductible (\$155 per calendar year in 2010).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

PLAN D includes the **basic benefit, plus**

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

PLAN F¹ includes the **basic benefit, plus**

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges².
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

PLAN G includes the **basic benefit, plus**

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 100% of Medicare Part B excess charges².
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

Effective June 2010, Medigap policies E, H, I and J are no longer sold to new policyholders. However, individuals who had an E, H, I or J policy prior to June 2010 can keep their policy.

PLAN K³ includes the **basic benefit, plus**

- Coverage for 50% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 50% of the Medicare Part A hospital deductible.
- Coverage for 100% of the Part A coinsurance amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A coinsurance amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 50% hospice cost-sharing.
- Coverage for 50% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 50% of the skilled nursing facility care daily coinsurance amount.
- Annual out of pocket limit of \$4,620 in 2010.

¹ Plan F also has a "high deductible option." If you choose the "high deductible option," you will first have to pay a \$2,000 deductible in 2010 before the plan pays anything. This amount can go up every year. High deductible policies have lower premiums.

² Plan pays the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

³ The basic benefits for plans K and L include similar services as plans A-G, but the cost-sharing for the basic benefits is at different levels. The annual out-of-pocket limit can increase each year for inflation.

PLAN L³ includes the **basic benefit, plus**

- Coverage for 75% of Part B coinsurance after you meet the yearly deductible for Medicare Part B, but 100% coinsurance for Part B preventive services.
- Coverage for 75% of Medicare Part A hospital deductible.
- Coverage for 100% of the Part A coinsurance amount for days 61-90 of hospitalization in each Medicare benefit period.
- Coverage for 100% of the Part A coinsurance amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage for 75% hospice cost-sharing.
- Coverage for 75% of Medicare-eligible expenses for the first 3 pints of blood.
- Coverage for 75% of the skilled nursing facility care daily coinsurance amount.
- Annual out of pocket limit of \$2,310 in 2010.

Plan M includes the **basic benefit, plus**

- Coverage for 50% of the Medicare Part A deductible.
- Coverage for 100% of the skilled nursing facility daily co-insurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

Plan N includes the **basic benefit, plus**

- Coverage for 100% of the Medicare Part B co-insurance amount, except for up to \$20 co-payment for office visits and up to \$50 co-payment for emergency room visits.
- Coverage for 100% of the Medicare Part A deductible.
- Coverage for 100% of the skilled nursing facility daily co-insurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible and \$50,000 lifetime maximum benefit.

Medicare SELECT: In addition to the standard Medigap policies A-N, Medicare SELECT is a type of Medigap policy that can cost less than standard Medigap plans. However, you can only go to certain hospitals and in some cases, certain doctors for your care. Visit www.ins.state.ny.us.caremain.htm for information on Medicare SELECT plans available in New York State.

Always consider inquiring about a particular membership or group insurance rate that might be less expensive than purchasing an individual plan on your own.

See tables on pages 17 and 18 for more information on Medigap policies.

Benefits Included in the Ten Standard Medicare Supplement Plans

Basic Benefit: Included in All Plans

- **Hospitalization:** Part A coinsurance, coverage for 365 additional days after Medicare benefits end, and coverage for 60 lifetime reserve days coinsurance.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses).
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A cost sharing.

| A | B | C | D | F* | G | K | L | M | N |
|---------------|-------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------------|-----------------------------------|-----------------------------|-----------------------------|
| Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit | Basic Benefit*** | Basic Benefit*** | Basic Benefit*** | Basic Benefit*** |
| | | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance (50%) | Skilled Nursing Coinsurance (75%) | Skilled Nursing Coinsurance | Skilled Nursing Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible (50%) | Part A Deductible (75%) | Part A Deductible (50%) | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | |
| | | | | Part B Excess | Part B Excess | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | | | | Out of Pocket limit \$4,620 | Out of Pocket limit \$2,310 | | |

MEDICARE SUPPLEMENT INSURANCE POLICIES

Prepared by the NYC Department for the Aging's Health Insurance Information Counseling Assistance Program (HIICAP) 1-212-341-3978. Please call the individual companies directly for their most current monthly rates as they are subject to change. Updated rate charts are available at the NY State Department of Insurance website at <http://www.ins.state.ny.us/medplan/medsup10.pdf>.

| <u>PLAN</u> | <u>Aetna</u> 800-345-6022 | <u>American Progressive</u> 800-332-3377 | <u>Bankers Conseco</u> 800-845-5512 | <u>Empire Blue Cross Blue Shield</u> 800-261-5962 | <u>First United American</u> 800-331-2512 | <u>GHI</u> 800-444-2333 | <u>Humana</u> 800-486-2620 | <u>Mutual of Omaha</u> 800-775-1000 | <u>State Farm</u> 866-855-1212 | <u>Sterling Life</u> 888-858-8551 | <u>United Health (AARP)</u> 888-687-2277 |
|-------------|----------------------------------|---|--|--|--|--------------------------------|-----------------------------------|--|---------------------------------------|--|---|
| A | \$224.16 | \$205.69 | \$196.22 | \$139.70 | \$190.00 | \$173.45 | \$236.00 | \$198.84 | \$247.20 | \$240.31 | \$152.50 |
| B | \$259.91 | \$298.20 | \$247.91 | \$194.46 | \$244.00 | \$230.14 | \$251.00 | \$332.27 | \$331.01 | \$283.36 | \$207.75 |
| C | | \$381.50 | \$295.04 | \$269.09 | \$303.00 | \$277.50 | \$290.00 | | \$383.29 | | \$239.00 |
| D | | \$345.71 | \$277.64 | | \$295.00 | | | | | | \$223.25 |
| E | | \$337.94 | \$278.86 | | | | | | | | \$224.00 |
| F | \$307.33 | \$397.55 | \$298.00 | \$294.73 | \$305.00 | | \$291.00 | \$358.78 | \$422.13 | | \$240.25 |
| F+ | | \$158.71 | \$92.72 | | \$92.00 | | \$117.00 | | | | |
| G | | \$359.52 | \$280.78 | | \$296.00 | | | \$237.71 | | | \$224.50 |
| H | | | | \$253.00 | | | | | | | \$254.75 |
| I | | | | | | | | | | | \$257.00 |
| J | | | \$298.98 | | | | | | | | \$284.25 |
| K | | | \$146.59 | \$107.86 | \$131.00 | | \$140.00 | | | \$135.26 | \$107.25 |
| L | | | \$208.74 | \$146.90 | \$184.00 | | \$203.00 | | | | \$149.25 |

MEDICARE AS SECONDARY PAYER WHO PAYS FIRST?

When a person has Medicare and other health insurance coverage, it is necessary to determine which insurance is primary, and which is secondary. The primary insurance is the one that will consider the claim first and the secondary insurance will consider any balance after the claim has been paid or denied by the primary insurance.

The issue of who pays first tends to arise for beneficiaries with original Medicare (Parts A and B) plus other insurance, such as the following:

Employer Insurance and Medicare:

| YOU ARE... | YOUR EMPLOYER HAS... | MEDICARE WILL PAY... |
|---|---|---|
| 65+ covered by employer plan | Less than 20 employees | First. Employer plan second. |
| 65+ covered by employer plan | More than 20 employees | Second. Employer plan first. |
| 65+ covered by spouse's employer plan | Less than 20 employees | First. Employer plan second. |
| 65+ covered by spouse's employer plan | More than 20 employees | Second. Employer plan first. |
| Under 65 covered by employer plan | Less than 100 employees | First. Employer plan second. |
| Under 65 covered by employer plan | More than 100 employees | Second. Employer plan first. |
| Under 65 covered by other family member plan | Less than 100 employees | First. Employer plan second. |
| Under 65 covered by other family member plan | More than 100 employees | Second. Employer plan first. |
| Any age with End Stage Renal Disease (ESRD) covered by employer plan of self or other family member | Any number of employees | Second for the first 30 months of Medicare enrollment. |
| Any age with COBRA benefits | Only companies with 20 or more employees (as per COBRA statute) | First. COBRA pays second except for ESRD patients whose COBRA plan pays first for the first 30 months of Medicare enrollment/eligibility. |

Liability Insurance and Medicare: In situations of an accident or injury, the expenses of medical care may be covered by other types of insurance such as no-fault or automobile insurance, homeowners or malpractice policies. Since many of these claims take a long time to be settled, Medicare can make conditional payment to avoid delays in reimbursement to providers and liability to beneficiaries. Medicare will pay the claim and later seek to recover the conditional payment from the settlement amount.

Worker's Compensation and Medicare: Worker's Compensation is usually primary in the event of a job-related injury and covers only health care expenses related to the injury. Pre-existing conditions can be paid by Medicare if Worker's Compensation does not cover these conditions.

Working After Age 65-Employer Group Health Plans (EGHP) and Medicare: When a Medicare beneficiary over age 65 continues to work, their employer or their spouse's employer must provide the same coverage for all employees and families, regardless of age. If there are 20 or more employees in the company where a Medicare beneficiary or spouse work, the EGHP is primary and Medicare is secondary. If there are fewer than 20 employees, then Medicare is primary and the EGHP is secondary. Medicare Part B is always open to those who are working who have employer coverage. Look on the Medicare website at www.medicare.gov or call 1-800-MEDICARE for more information. Some employers require that those who are eligible for Medicare enroll in Medicare Parts A and/or B; it is advised to contact the employer about this issue.

When the employee chooses to retire, he needs to consider enrolling in Medicare Part B, since Medicare Part B will be his primary insurance upon retirement. There is a monthly premium for Part B. Enrollment in Medicare Part B should be done within 8 months of the end of active employment, not at the end of health care coverage, in order to avoid a penalty.

Disability and Medicare: If a person becomes disabled and is unable to work, an EGHP generally covers the costs. If the company employs 100 or more individuals, the EGHP is primary and Medicare is secondary. If there are fewer than 100 employees, Medicare is primary and the EGHP is secondary. Disability, as determined by Social Security, will entitle an individual to Medicare coverage after the 24th month of disability payments without regard to age.

End Stage Renal Disease (ESRD): Some individuals are eligible for Medicare Part B coverage because they have End Stage Renal Disease and are either receiving maintenance dialysis treatments or have had a kidney transplant. If there is an employer group health plan, it is primary during the first 30 months of Medicare eligibility. After 30 months, Medicare is primary.

Federal Black Lung Program and Medicare: The Federal Black Lung Program provides services related to lung disease and other conditions caused by coal mining. Medicare will also cover services unrelated to black lung for these same individuals.

Please visit www.medicare.gov for more information or call 1-800-MEDICARE.

MEDICARE ADVANTAGE PLANS HMOs, PPOs, Special Needs Plans (SNP) and Private Fee-For-Service Plans (PFFS)

Medicare Advantage plans provide beneficiaries in New York City with alternatives to “original fee-for-service” Medicare. Medicare Advantage plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service plans (PFFS). HMOs and PPOs involve a network of doctors, health centers, hospitals, skilled nursing facilities and other care providers for the enrolled member to use for their medical needs. In a PFFS plan, you may go to any Medicare-approved doctor or hospital that will accept the plan’s payment.

Medicare Advantage plans’ networks can be local, statewide, and even national. It is important to contact the plan to understand the scope of the provider network, especially if you travel and may require care other than emergency care outside your area of residence.

If you wish to have prescription drug coverage and belong to an HMO, PPO or SNP, you must get the drug coverage through your plan. If you belong to a PFFS plan that does not offer prescription drug coverage (Part D), you can join a stand alone Prescription Drug Plan (PDP).

Every Medicare Advantage plan must provide its members with all of the same medically-necessary services that “original” Medicare covers, and may include additional services, such as a prescription drug benefit and vision, dental and hearing services. All Medicare beneficiaries have the right to obtain the needed medical services, to get full information about treatment choices from their doctor and to appeal any denial of services or reimbursement made by an HMO, PPO, SNP or PFFS plan.

Each member of a Medicare Advantage plan must receive a Summary of Benefits as part of the enrollment process. Key information about additional premiums, routine procedures, access and notification requirements in an emergency, and co-payments for services must be outlined. A provider directory, a list of pharmacies in the plan and a formulary list of covered medications are also available from the plan.

Obtaining Services in Original Fee-for-Service Medicare, HMOs, PPOs, Special Needs Plans (SNP) and PFFS plans

Original Fee-For-Service Medicare entitles the beneficiary to obtain all medically-needed services from any Medicare provider anywhere in the United States. Medicare sets the fees for those services and covers 80% of costs. The beneficiary is responsible for the balance. Medicare supplement insurance (see page 9) can cover all or most of the senior’s share of the costs.

HMOs require the Medicare beneficiary to select a primary care physician (PCP) from the HMO's network of local doctors. Some HMOs require that the PCP provide a referral to specialists, though most do not require such referrals for in-network providers. Since the HMO receives a subsidy from the federal government, costs to the beneficiary may be lower than in fee-for-service Medicare. An HMO may offer additional benefits to those offered in fee-for-service Medicare, such as vision and dental care. There is no coverage for services obtained out-of-network; the beneficiary will be responsible for the full costs of such services.

PPOs provide a network of health care providers but do not restrict the enrollee from going out-of-network. The PPO sets its payment to in-network providers with a fixed co-pay from the enrollee; enrollees will pay more for services from out-of-network providers. (Out of network providers are subject to Medicare's limiting charge, which limits the amount they can charge a Medicare beneficiary for services.) Additional health benefits may be included in a PPO's plan, such as vision and dental.

Special Needs Plans (SNP) are Medicare Advantage plans (HMOs or PPOs) that are geared to people with specific diseases or health conditions. Examples of people who might be eligible to join a Medicare SNP include: people with both Medicare and Medicaid; people with mental illness; people with HIV/AIDS; and people living in an institution, such as a nursing home. SNP coverage includes services covered by Medicare Parts A and B, as well as prescription drug coverage. They may also cover services and prescriptions that may be needed by the specific population to which they are geared. Generally, SNPs follow the same timeline for enrollment as Medicare Advantage plans, though people who are newly diagnosed with a condition (and meet other qualifying criteria) have a special enrollment period.

Private Fee for Service Plan (PFFS) members can go to any Medicare approved providers who agree to accept the plan's terms and conditions of payment. The provider can charge you the difference between what the PFFS plan pays and their usual fees. In addition, even if the provider has treated you in the past, with PFFS Medicare, providers can decide whether or not to treat you before each service.

To request a list of available HMOs, PPOs and PFFS plans in NYC, please call the HIICAP office at 212-442-0922. You can also find helpful information in the Medicare and You Handbook or by calling 1-800-MEDICARE.

Frequently Asked Questions about Medicare Advantage Plans

Who is Eligible to Enroll in a Medicare Advantage Plan?

In order to be eligible to enroll in a Medicare Advantage Plan, you must have both Medicare Part A and Part B; you must live in the plan's service area; and you cannot have permanent kidney failure. A Medicare Advantage plan cannot turn away an applicant because of health problems.

How is a Medicare Advantage Plan Paid?

When you choose to join a Medicare Advantage plan, the Centers for Medicare and Medicaid Services (CMS) pays the company a set amount each month to cover the medical services the average beneficiary is expected to need. Your Medicare Part B premium is still deducted from your Social Security check and is then turned over to the Medicare Advantage plan.

What Are My Out of Pocket Costs in a Medicare Advantage Plan?

Each Medicare Advantage plan sets its own premiums and cost sharing schedule. You may pay a monthly premium directly to the plan, which is in addition to the Part B premium. All cost sharing requirements must be clearly indicated to you on your benefit card or in your summary of benefits. Call the plan if you are not sure. There may be co-pays, co-insurance and deductibles for health services. Some Medicare Advantage Plans have maximum out-of-pocket costs per year, which limits how much you will have to pay out-of-pocket in a given calendar year.

How Does a Medicare HMO Work?

In an HMO, you select a Primary Care Physician (PCP) who is responsible for managing your medical care, admitting you to a hospital, ordering diagnostic tests and treatments, providing referrals to specialists, and writing your prescriptions. You have a choice of physician, provided he or she is available for new patients. You must receive your health care from the HMO's providers; Neither the HMO nor Medicare will pay for services from providers who are not part of the HMO's health care network, except in emergency situations.

How Does a Medicare PPO work?

A PPO is a network of doctors, hospitals and other providers. The enrollee can get services from within the network or go out of network. If you stay within the PPO's network, you will pay a co-payment (a set amount for certain services) that is probably less than the cost-sharing in "original" Medicare. If you go outside of the PPO's network with a referral to another provider or select another doctor or specialist, you will have to meet the plan's deductible and pay a higher fee for these services. The PPO will pay a set amount of the fee and you will pay the balance.

How do Medicare Advantage Plans work with Medicare Part D (drug coverage)?

If you are in a Medicare Advantage Plan and want to have prescription drug coverage, you must get that coverage through your plan; you cannot join a separate Part D (stand-alone) plan.

What about Emergency Services?

Emergency medical care will be covered by the Medicare Advantage plan provided that you follow its requirements for notifications and approval. You may be required to pay the provider of services first, and then file a claim with the plan for reimbursement. If the plan determines the need for care does not meet its conditions, or if the notification was faulty, it may refuse to cover the costs.

How Can I Appeal a Decision By My Health Plan?

Decisions by your plan not to provide or pay for a service are handled by their claims department. If you are refused Medicare-covered services or denied payment for Medicare-covered supplies or treatments, you must be given a notice which will include your right to appeal.

How Do I Complain About Quality of Care?

If your complaint is related to the quality of health care you receive, you should follow your plan's grievance procedures. You can also present your case to the Medicare Quality Improvement Organization (QIO), IPRO in New York State, whose doctors and other professionals review the care provided to Medicare patients. IPRO can be reached at 1-800-331-7767.

How Should I Decide Whether to Join a Medicare Advantage Plan?

Consideration should be given to the following three areas before joining a plan:

- 1) your current doctors' accepting of the plan; 2) finances and 3) geographical location.
1. **Will you be able to continue seeing your doctors?** Ask your doctors what plans they participate in and whether they are accepting new Medicare patients under that particular plan. Even if you already have an established relationship with that doctor, you need to be certain that they will accept you as a new patient under that particular plan.
2. **Finances:** Receiving care through a Medicare Advantage plan may cost you less than receiving care through original Medicare. Medicare Advantage plans also may cover services which are not covered by original Medicare, such as routine vision and dental care, as well as eyeglasses. It is important to research the fee structure in a Medicare Advantage plan before enrolling. Also, it is vital to make sure that you review this information at the end of each year for the upcoming year, since plans can change their fee structure annually, with changes effective January 1 of each year.

3. **Geographical Location:** It is important to think about your travel plans when deciding whether a Medicare Advantage plan is right for you. Because Medicare Advantage HMO plans have defined geographic areas that they serve, if you plan to be outside of the service area for any length of time, an HMO may not be right for you, since only emergency care is covered outside the plan's service area. The service area of PPO and PFFS plans are less restrictive.

What If I Want to Leave My Medicare Advantage Plan?

From November 15-December 31, you can change your Medicare Advantage (MA) plan choice or return to "original" Medicare, with the change effective January 1. From January 1 – March 31, during the Open Enrollment Period (OEP), you can make one change to how you receive your health coverage, either to return to original Medicare or to switch to another Medicare Advantage plan; the change will be effective as of the first of the following month, so if you switch plans in January, the change would be effective in February. Individuals with Medicaid, a Medicare Savings Program or Extra Help can switch plans at any time, with the change effective the first of the following month.

NEW: In calendar year 2011, the OEP will be replaced by the MA Annual 45 Day Disenrollment Period (ADP), during which an MA plan member can switch to Original Medicare within the first 45 days of the calendar year.

If you decide to end your enrollment in a plan, you must send a written, signed request to your HMO or PPO, or notify your local Social Security or Railroad Retirement office, of this decision. If you want to leave one Medicare Advantage plan and enroll in another Medicare Advantage plan, contact the plan in which you wish to enroll (or 1-800-MEDICARE); you do not need to submit a written request.

Will I Need A Medicare Supplement Insurance Policy?

You will not need a Medicare supplement insurance policy ("Medigap") if you join a Medicare Advantage plan, as the "Medigap" would duplicate your benefits. If you decide to join a Medicare Advantage plan, and you already have a Medigap policy, you may want to retain it for at least 30 days, until you see if the Medicare Advantage plan is satisfactory. By New York State law, you will always be able to purchase a "Medigap" policy if you leave an HMO, PPO, SNP or PFFS plan and return to "original" Medicare, but you may face a period of non-coverage for a current health condition. For more about "Medigap," see page 10.

MEDICARE SAVINGS PROGRAMS

Medicare Savings Programs (MSP) can help eligible clients pay for their Medicare premiums and other costs associated with Medicare. MSPs are administered by the Human Resources Administration (HRA) in New York City. Applications can be obtained at a Medicaid office or at:

www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/msapp.pdf. Individuals can mail applications to: Medical Assistance Program, Correspondence Unit, 330 West 34th Street, 9th Floor, New York, NY 10001.

Below is information on the Medicare Savings Programs, followed by income and resource limits for each of the programs:

- **Qualified Medicare Beneficiary Program (QMB):** This program can pay for the Medicare Part A and/or Part B premium, as well as the coinsurance and deductibles for Parts A and B. An individual can be eligible for QMB only, or for QMB as well as Medicaid. Individuals with QMB must see providers who accept both Medicare and Medicaid if they want full Medical coverage with no out-of-pocket costs.
- **Specified Low Income Medicare Beneficiary Program (SLMB):** This program pays for the Medicare Part B premium. Individuals can be eligible for SLMB only, or for SLMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for SLMB.
- **Qualified Individual (QI):** This program pays for the Medicare Part B premium. Individuals cannot be eligible for both QI-1 and Medicaid. The applicant must have Medicare Part A to be eligible for QI-1. States are allotted money for this program on a yearly basis.
- **Qualified Working and Disabled Individual (QWDI):** This program pays for the Medicare Part A premium only, not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work.

| MSP Monthly Income and Resource Limits (after any deductions/exclusions) | | | | |
|---|---------------|-----------|-----------------------|-----------|
| | Single | | Married Couple | |
| | Income | Resources | Income | Resources |
| QMB: 100% FPL | \$903 | No Limit | \$1,214 | No Limit |
| SLMB: 120% FPL | \$1,083 | No Limit | \$1,457 | No Limit |
| QI: 135% FPL | \$1,218 | No Limit | \$1,639 | No Limit |
| QWDI: 200% FPL | \$1,805 | \$4,000 | \$2,428 | \$6,000 |

Medicare Savings Program Advocacy Tips:

- Individuals in an MSP are automatically eligible for full Extra Help for paying for Medicare Part D prescription drug coverage (see page 27).
- You do not need to go to a Medicaid office to apply for an MSP.
- If you are working, you may still qualify for a Medicare Savings Program.

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

Medicare Part D is prescription drug coverage offered through private insurance companies to help cover the cost of prescription drugs.

Medicare prescription drug plans are available to all people with Medicare (Part A and/or Part B). A result of the Medicare Modernization Act of 2003, Medicare Part D adds prescription drug coverage benefits to Medicare's existing health benefits of Part A (hospitalization), Part B (outpatient services), and Medicare Advantage Plans (HMOs, PPOs, Private Fee for Service Plans). Part D is a voluntary benefit; Medicare beneficiaries are not required to join a plan, although there may be a penalty for late enrollment.

Medicare Part D is unlike Parts A or B, as it is not standardized nationally but instead is offered through private-sector companies. Each private company designs its own plan for Medicare consumers. These plans have all entered into a contract to provide Medicare Part D drug coverage through the Centers for Medicare and Medicaid Services (CMS) which regulates the plans and categories of covered drugs. When you sign up for a Part D plan, you are applying directly to a private company who negotiates the costs of your drugs with pharmacies, and has its own list of covered medications (formulary) and participating pharmacies, as well as its own procedures for getting a new drug covered or appealing to have a medication covered to meet your own special needs.

Those electing to join a Part D plan will have to pay a monthly premium and pay a share of the cost of prescriptions. Drug plans vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans have to provide at least a standard level of coverage, which Medicare sets. However, some plans offer enhanced benefits and may charge a higher monthly premium. When a beneficiary joins a drug plan, it is important to choose one that meets the individual's prescription drug needs.

Although Part D plans' benefit designs vary, they each include the following minimum levels of coverage in 2010:

- Deductible (up to \$310). Some plans have a lower deductible or no deductible.
- Initial Coverage Level. You pay 25% of drug costs up to \$2,830 in total drug costs (Total drug costs include the amount that you pay for the drug plus the amount that the plan pays for the drug).
- Coverage Gap (also known as the "donut hole"). You pay 100% of drug costs from \$2,830-\$6,440, until **you** have spent \$4,550 in out-of-pocket costs. This includes the deductible (if any) plus any co-payments or coinsurance paid while reaching the Coverage Gap.

- Catastrophic Coverage (after \$4,550 in out-of-pocket expenses). The beneficiary is responsible for the greater of five percent (5%) of drug costs or a \$2.50 co-payment for generic medications and \$6.30 for brand-name drugs.

NEW: In 2010, beneficiaries who reach the coverage gap (“donut hole”) will receive a one-time \$250 payment in the 3rd month following the end of the calendar quarter in which they enter the coverage gap. The coverage gap will gradually be reduced beginning in 2011, with a 50% discount on brand name drugs purchased during the gap, and ending in 2020, with a flat 25% co-payment for both brand and generic drugs until catastrophic coverage is reached.

Medicare Part D is offered in one of two ways:

1. Medicare Advantage Prescription Drug Plans (MAPDs): these are managed care plans, such as HMOs, PPOs, or SNPs, which offer comprehensive benefits packages that cover all of the following: hospital, doctors, specialists, pharmacy and prescriptions. If you are in a Medicare Advantage plan and want to have Part D coverage, you must get Part D coverage through your Medicare Advantage plan.
2. Stand Alone Prescription Drug Plans (PDPs): these plans **ONLY** cover prescription drugs. While there are 50 different PDPs in 2010, in the New York State region, that does not mean there are 50 different companies, since some companies offer several plans.

Extra Help with Drug Plan Costs for People with Limited Incomes

The Social Security Administration (SSA), through which people sign up for Medicare Parts A and B, provides a subsidy, paid directly to the drug plans, for Medicare beneficiaries with lower incomes and limited resources. Individuals with monthly incomes up to 135% of the Federal Poverty Level, \$1,218 (\$1,639 for couples) and resources up to \$8,100 (\$12,910 for couples) in 2009 may qualify for **full Extra Help**, also known as the Low-Income Subsidy Program. Those qualifying for full Extra Help will not have a monthly premium for their Part D plan, as long as the plan selected is considered a “benchmark” plan. A benchmark plan is a Part D plan that has been designated by Medicare to meet certain coverage requirements and has a monthly premium that is fully subsidized by Extra Help (monthly premium up to \$33.32 in 2010). Individuals with full Extra Help will not be subject to the plan’s deductible, if any, and their co-pays will be limited to \$2.50 for generic prescriptions and \$6.30 for brand name prescriptions.

Individuals with monthly incomes up to 150% of the Federal Poverty Level, \$1,354 (\$1,821 for couples) in 2009 and resources up to \$12,510 (\$25,010 for couples) may qualify for **partial Extra Help**. Those with partial Extra Help will pay a monthly premium on a sliding scale based on their income. In addition, they will be responsible for a deductible of up to \$63 and reduced co-pays of 15% of drug costs until they reach catastrophic levels, after which they pay the standard co-pay amounts.

HIICAP counselors can help determine eligibility for this benefit, as can the Social Security Administration. Call 311 to find help near you, or call SSA at 1-800-772-1213 (1-800-325-0778 TTY) or apply online at www.socialsecurity.gov. You may apply for

Extra Help through SSA at any time and if you qualify, you will receive a Special Enrollment Period for selecting a Medicare Part D drug plan. Individuals with Extra Help will not be subject to a penalty for late enrollment in Part D.

Enrollment in Medicare Part D

Enrollment in Medicare Prescription Drug Coverage involves choosing a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD) offering drug coverage. Comparison information is available on www.medicare.gov or by calling 1-800-MEDICARE.

Enrollment in Part D can occur during one's seven month Initial Enrollment Period (IEP), (see pages 3-4 for more information). In addition, a beneficiary may join or change plans once each year between November 15 and December 31, during the Annual Coordinated Election Period (AEP). There are also limited exceptions where a beneficiary would be granted a Special Enrollment Period (SEP) to enroll in a Medicare Prescription Drug Plan or to switch plans outside of the AEP. These include the following situations:

- Permanent move out of the plan service area.
- Individual entering, residing in, or leaving a long-term care facility.
- Involuntary loss, reduction, or non-notification of "creditable" coverage.
- Prescription Drug Plan withdrawal from service area.
- Dual eligible beneficiaries (those with **both** Medicare **and** full Medicaid), individuals in a Medicare Savings Program (QMB, SLMB, or QI), and those with Extra Help, can switch plans as often as every month, to be effective the first of the following month.

You can apply to join a Medicare Part D plan in several ways:

- Electronically on the internet, either through www.medicare.gov or the plan's website.
- Over the telephone by calling 1-800-MEDICARE or by calling the plan directly.
- In person, through a Part D plan's representative during a scheduled home visit or at a sales/marketing event.

Late Enrollment Penalty

Even if a person with Medicare does not use a lot of prescription drugs now, they should still consider joining a plan. If a beneficiary does not have creditable coverage (coverage for prescription drugs that is at least as good as the standard Medicare Prescription Drug Coverage), they will have to pay a penalty if they choose to enroll later. Others with creditable coverage, such as through a former employer or union, the Veterans Administration (VA), TRICARE for Life, or EPIC, will not experience a penalty for late enrollment. The penalty is equivalent to one percent (1%) of the "base premium" (\$31.94 in 2010) per full month that the person with Medicare was not enrolled in a Medicare Prescription Drug Plan and did not have creditable coverage. This penalty needs to be paid for as long as you have Part D coverage. If the beneficiary has had creditable coverage with a gap of no more than 63 days from when that coverage ended and the Medicare Part D coverage begins, they will not be subject to a penalty. There is no late enrollment penalty for people with full or partial Extra Help.

Cost Utilization Management Tools

In an effort to control costs, Medicare Prescription Drug Plans employ the following cost utilization management tools– Tiers, Prior Authorization, Step Therapy, and Quantity Limits.

- **Tiers:** Most Part D plans divide their formulary (list of covered medications) into “tiers” and encourage the use of drugs covered under a lower tier by assigning different co-payments or coinsurance for the different tiers. Generally, generic drugs fall under a lower tier and cost less than drugs covered under a higher tier, such as brand-name medications.
- **Prior Authorization:** Although a plan may cover a medication in its formulary, they may require that a doctor contact the plan to explain the medical necessity for that particular drug.
- **Step Therapy:** A Part D plan may require a beneficiary to try less expensive drugs for the same condition before they will pay for a more expensive, brand name medication. However if a beneficiary has already tried the less expensive drugs they should speak to their doctor about requesting an exception.
- **Quantity Limits:** For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. For instance, a plan may only cover up to a 30-day supply of a drug at a time. However, regardless of the quantity they approve, the same co-payment applies.

How Do I Select A Part D Plan?

To select a Part D plan for your specific needs, it is best to use the personalized plan finder tool at www.medicare.gov. You can either do a “personalized search,” whereby you input your personal Medicare information, or a “general search,” for which you don’t need any of your personal Medicare information.

You will input the names of the medications you are currently taking or expect to take in the upcoming year, along with the dosages and quantity needed for a 30-day supply. It is best to ask for a listing of your medications from your pharmacist before you start this process.

You will be asked to select up to two pharmacies that you would like to include in your search. After you have input all of the information, the plan finder will provide a listing of the Part D plans, sorted from least expensive to most expensive. It is important to look at the details of each plan to understand what cost utilization management tools, if any, may apply. It is also advised to call up the plan to verify the information.

When you have selected the plan that’s right for you, you can enroll online or by phone. If you would like help using the Plan finder, please contact a HIICAP counselor.

Do I need a Part D Plan if I Have Employer Health Coverage?

You may not need to enroll in a Part D plan if you have health coverage through a current or former employer. The current or former employer should advise you, usually through a letter, as to whether or not you should enroll in a Part D plan. If you do not receive a letter, contact the employer to determine whether to enroll in a Part D plan. This is vital, since *enrollment in a Part D plan may compromise all health benefits through that employer, not just prescription drug coverage.*

Do I Need a Part D Plan if I Don't Take any Medications?

Having a Part D prescription drug insurance plan is optional, though it is important to remember that most people can only sign up for a plan during the Annual Election Period (AEP), from November 15-December 31 of each year. It may be advisable to explore the least expensive plan in case your drug needs change in the coming year. Also remember that you may face a late enrollment penalty if you do not enroll when you are first eligible.

NEW YORK STATE EPIC PROGRAM

(ELDERLY PHARMACEUTICAL INSURANCE COVERAGE)

The Elderly Pharmaceutical Insurance Coverage program (EPIC) is New York State's prescription drug insurance program for New York State's senior citizens. If you are 65 years old or over, live in New York State, and have an income of up to \$35,000 for singles and \$50,000 for married couples, you may be eligible for EPIC.

EPIC enrollees may purchase prescriptions at 4,500 participating pharmacies across New York State by showing their EPIC card. Enrollees pay a reduced rate for prescriptions depending on the cost of the medication. For example: for a prescription costing between \$15 and \$35, they pay \$7. The highest co-pay is \$20, regardless of the regular price of the prescription.

If you have Medicare Part D, Medicaid spenddown, or limited prescription drug coverage, EPIC may be used to supplement that coverage to further reduce prescription drug expenses. Individuals with full Medicaid are not eligible for EPIC.

How much will my prescriptions cost with EPIC?

| | |
|------------------------------------|--------------|
| Prescriptions costing up to \$15 | You pay \$3 |
| Prescriptions costing \$15.01-\$35 | You pay \$7 |
| Prescriptions costing \$35.01-\$55 | You pay \$15 |
| Prescriptions costing over \$55 | You pay \$20 |

EPIC Fee and Deductible Plans

There are two plans within EPIC, the Fee Plan and the Deductible Plan. Applicants do not have a choice of which plan to join; EPIC makes this decision based on the individual's/couple's income.

EPIC's Fee Plan is for individuals with annual incomes up to \$20,000 and married couples with incomes up to \$35,000. To participate in the Fee Plan, participants pay the annual fee associated with their income. After paying the fee, participants pay the EPIC co-pay for their medications. Fees are based on the previous year's annual income and are paid quarterly. For example: a single person with an income of \$16,000 is responsible for an annual fee of \$140. A couple with an income of \$24,000 would pay \$275 per person to participate in EPIC's Fee Plan.

EPIC's Deductible Plan is for individuals with annual incomes between \$20,001 and \$35,000, and married couples with incomes between \$35,001 and \$50,000. To participate in the Deductible Plan, participants pay for their prescriptions until they meet their EPIC deductible amount, which is based on the previous year's income. After meeting the deductible, participants pay only the EPIC co-pay. For example, a single person with an income of \$22,000 must meet an annual deductible of \$580. For a couple with an income of \$41,000, each person must meet an annual deductible of \$1,230.

How Does EPIC Work with Medicare Part D?

EPIC now requires most of its members to also be enrolled in a Medicare Part D plan (see the Medicare Part D section, page 26, for more information), with Part D coverage being primary and EPIC coverage being secondary. (However, EPIC does not require most of its members in Medicare Advantage plans without Part D coverage to enroll in a MA plan with Part D coverage.) The enrollee pays the EPIC co-pay based on the amount remaining after the Part D plan pays, thus reducing the enrollee's costs. For example, if you are responsible for paying a \$20 co-pay for a drug using your Part D Plan and also have EPIC, you would pay the EPIC co-pay on a \$20 drug, which is \$7. In addition, EPIC will cover you during the Part D deductible and "donut hole" (the Part D coverage gap). Medications that are, by law, not covered by Part D plans can be covered by EPIC.

EPIC has made programmatic changes to maximize the use of beneficiaries' Part D plans, as well as the use of generic drugs:

- **Follow Part D Plan's Formulary:** Drugs not covered under the Part D plan's formulary can be covered by EPIC, though EPIC first requires the pharmacist to contact the prescriber to ask them if they would consider prescribing a medication covered by the Part D plan. EPIC will be a secondary payer for Part D plan members who use certain mail order pharmacies, even if that mail order pharmacy is outside of NY State. (EPIC will not pay the out-of-state pharmacy for a drug not covered by the Part D plan.)
- EPIC will require and assist its members who are potentially eligible for a Medicare Savings Program to apply for the MSP.
- **EPIC Appeals:** For drugs not on the Part D plan's formulary, EPIC may submit an appeal to the Part D plan to request an exception to the plan's formulary. The enrollee does not need to take any action on this measure; EPIC will handle all contact with the Part D plan and the enrollee's prescriber.
- **Mandatory Generic Drug Program:** For seniors with EPIC only, who are prescribed a brand name drug with an "A" rated generic equivalent, the pharmacy will contact the prescriber to see if the enrollee can receive the generic drug. If the prescriber wants the enrollee to have the brand name drug, they must call EPIC's Prior Authorization Call Line at 1-800-256-8082. This may also affect people with Part D when the drug with an "A" rated generic is not covered by the Part D plan.

EPIC helps its enrollees to select a Part D plan that best fits their drug and pharmacy needs. For those in the Fee Plan, EPIC will pay the Part D premium, up to \$33.32 per month in 2010, which is the amount of a "benchmark" plan. For EPIC enrollees in the Deductible Plan, EPIC will reduce the amount of the deductible by \$33.32 per month (\$399.84 year) to help pay for the Part D premium which they are required to pay. EPIC enrollees with full Extra Help will have their EPIC fee waived; those with partial Extra Help are responsible for paying their enrollment fee.

How to Enroll In EPIC

Call 1-800-332-3742 to obtain an enrollment form and to ask any questions you have about the program. You can also visit www.nyhealth.gov/health_care/epic/index.htm for more information or to download an application form.

NEW YORK PRESCRIPTION SAVER CARD (NYP\$)

The New York Prescription Saver Card (NYP\$) is a new program, effective April 1, 2009, sponsored by New York State. The NYP\$ card offers a discount for eligible New York State residents when they purchase their prescriptions at participating pharmacies.

NYP\$ is a free discount card for all who are eligible – there are no costs to join or use this card. The NYP\$ card is not insurance, but rather a discount card, offering savings of up to 60% on generics and 30% on brand name drugs. Most drugs are covered under the NYP\$ program.

Eligibility

To be eligible for the NYP\$ card, you must be:

- A resident of New York State; and
- Not receiving Medicaid (unless you have Medicaid with a spend down); and
- Have an annual income (in the previous calendar year) of up to \$35,000 (single) or \$50,000 (married); and
- Meet one of the following:
 - Age 50-64 **OR**
 - Any age and determined disabled by the Social Security Administration

Who might be good candidates for this card?

- Individuals of any age determined disabled by Social Security but who do not yet have Medicare coverage.
- Individuals under age 65 with Medicare Part D who may need drugs not on their plans' formularies or not covered under Part D;
- Individuals aged 50-64 with limited or no other drug coverage.

Interaction between NYP\$ and Medicare Part D

Disabled Medicare beneficiaries under age 65 can use the NYP\$ card instead of the Part D plan card while meeting the annual deductible and during the "donut hole;" however, your Part D plan also provides discounted prices during the deductible or "donut hole." You may use your NYP\$ card instead of your Part D plan, but the purchase will not automatically be credited toward your Part D out-of-pocket accumulation. You should contact your Part D plan; they may be willing to credit your discount card purchase if you send them a paper receipt.

You may use your NYP\$ card to purchase prescriptions not on the plan's formulary and those not covered under Medicare Part D.

Can the NYP\$ card be used with other discount cards?

No. You can have other prescription coverage and still be eligible for the NYP\$ card. However, you cannot use the discount card with another prescription discount or insurance card for the same prescription.

Application and Further Information

You can download an application or apply online at <https://nyprescriptionsaver.fhsc.com>, or call 1-800-788-6917 (TTY 1-800-290-9138) to request a paper application in the mail. More information can also be obtained by calling the number above or visiting the website.

MEDICAID

Medicaid is a joint federal, state and city government health insurance program for low-income individuals. Medicaid is a “means tested” program requiring applicants to prove their financial need in order to be eligible. Once determined Medicaid eligible, a permanent plastic Medicaid card is issued and is valid as long as he or she remains eligible. The enrollee uses it like a credit card for health care services at any medical facility that accepts Medicaid.

Medicaid-Covered Services

- Emergency & Hospital Services
- Preventive Services
- Personal Care Services
- Case Management Services
- Approved Prescription Medication
- Physical Therapy
- Speech and Hearing Rehabilitation
- Tuberculosis (TB) Related Services
- Mental Health Services
- Private Duty Nursing
- Hearing aids
- Diagnostic Services
- Occupational Services
- Clinic Services
- Screening Services
- Rehabilitative Services
- Hospice Care
- Eyeglasses & Optometry Services
- Dental Services and Dentures
- Prosthetic Devices
- Transportation

Medicaid Eligibility

The following eligibility criteria must be met for those age 65+, blind or disabled: Income and Asset Limits, Citizenship/Immigration criteria, and residency.

1. Income and Asset Limits for 2009

Single Individual:

- Maximum monthly income: \$767 per month
- Assets: \$13,800 (plus \$1,500 burial fund)

Married Couple:

- Maximum monthly income: \$1,117 per month
- Assets: \$20,100 (plus \$3,000 burial fund)

There are certain **income deductions**, so even if your income is over these amounts, you are encouraged to apply. Additionally, if your income is over these amounts, you may be eligible to participate in Medicaid’s Excess Income Program, whereby, each month, you spend down the amount by which you are over Medicaid’s allowed amount, in order to have Medicaid coverage. Moreover, if your income is over Medicaid’s allowed amounts, remember that you may be eligible for a Medicare Savings Program to help pay the Medicare premiums and other costs associated with Medicare (see page 24 for more information).

Assets include cash, bank accounts, IRAs and stocks. Certain assets are not counted towards these limits, including your primary home, your automobile and personal belongings.

2. Citizenship/Immigration

To be eligible for Medicaid, you must be a U.S. citizen or qualified alien.

3. Residency

You must live in New York State to apply for Medicaid in New York State. If you live in New York City, you must apply in New York City; you can apply in any borough, regardless of the borough of residence.

To Apply for Medicaid, you must complete and submit an application. The Access NY Health Care application, form DOH 4220, can be used by anyone applying for Medicaid. You can access the application and instructions, in both English and Spanish, at www.nyhealth.gov/nysdoh/fhplus/application.htm.

If you are applying for Medicaid to cover long term care services, including care in a nursing home or home health care, you must use application LDSS-2921. This application can be found at www.otda.state.ny.us/main/apps/2921.pdf.

Where do I submit the application?

You have a choice of where and how to submit your Medicaid application:

- Go to your local Medicaid office. See page 57 for a listing of Medicaid offices, or call the Human Resources Administration toll free at 1-877-472-8411, or 311.
- Contact a Facilitated Enroller. Facilitated enrollers are community agencies with staff that are trained to help with completing and submitting the Medicaid application. For a list of facilitated enrollers, call 1-877-934-7587 or go to www.health.state.ny.us/nysdoh/fhplus/where.htm.

How Does Medicaid Interact with Medicare Part D?

Most people with Medicaid and Medicare (known as “dual eligibles”) are required to join a Part D plan and will be automatically enrolled in a benchmark plan if they do not sign up for a plan on their own. Dual eligibles can change plans as often as every month, with the new coverage effective the first of the following month. (Note: Individuals with Medicaid only do not enroll in a Medicare Part D plan.)

Dual eligibles are automatically enrolled in full Extra Help (see page 27 for more information) and will pay a reduced amount for the prescription medications. Dual eligibles with incomes under 100% of the Federal Poverty Level will have co-pays of \$1.10 generic/\$3.30 brand name. Those with incomes over 100% FPL will have co-pays of \$2.50 generic/\$6.30 brand name. Duals will no longer pay co-pays once the total cost of covered drugs reaches the catastrophic level of \$6,440 in 2010.

Certain drugs, such as over-the-counter medications, benzodiazepines, barbiturates, and vitamins are, by law, not covered by Part D. These will continue to be covered by Medicaid.

VETERANS' BENEFITS AND TRICARE FOR LIFE

To receive health care at facilities operated by the Department of Veterans Affairs (VA), veterans must be enrolled with the VA. Veterans can apply for coverage at any time. Veterans who cannot afford to pay the cost of their care must provide the VA with financial information on their annual income and resources. Eligibility for free medical care is based on geographical income thresholds. Veterans not eligible for free care are responsible for a co-payment to the VA in the amount of \$15 or \$50, depending on the type of care received. Insurance coverage held by the veteran or a spouse will be used for payments first, with the balance of either the \$15 or \$50 charge being released to the veteran if the insurance company doesn't pay at least that amount. Nursing home and home health care services are available to qualified low-income veterans. Outpatient pharmacy services are provided free to veterans with service-connected conditions or low incomes. Medication co-payments apply to both over-the-counter and prescription drugs when purchased at the VA. Other veterans will be charged \$8 for a 30-day supply of medication.

The VA cannot bill Medicare, so veterans with Medicare *only* who are responsible for the co-pay for medical care will receive the appropriate charge for services. However, if there is a supplemental policy, the VA will bill the carrier first.

TRICARE Health Benefits provides coverage to the families of active duty service members, families of service members who died while on active duty, and retirees and their families, whether or not the veteran is disabled. TRICARE benefits consist of: TRICARE Prime, TRICARE Extra and TRICARE Standard. The programs differ on the use of a provider networks and cost sharing obligations.

Military retirees (and their spouses) having served at least 20 years who are 65 years or older and are currently enrolled in Medicare Parts A and B are eligible for **TRICARE for Life (TFL)**. TFL is a premium-free managed health care plan that acts as a supplement to Medicare and includes the **TRICARE Senior Pharmacy** program. For more information on TRICARE, call 1-877-363-6337 or visit www.tricare.osd.mil.

Civilian Health and Medical Program (CHAMPVA) is a health insurance program for dependents of 100% permanently and totally disabled veterans. CHAMPVA has an annual deductible of \$50 per person or \$100 per family per calendar year. In addition, there is a 25% co-insurance. Beneficiaries can select their provider; there is no provider network; providers cannot be on the Medicare exclusion list. If eligible for TRICARE, one cannot be enrolled in CHAMPVA. For more information on CHAMPVA, you can call the VA at 1-800-733-8387 or visit www.va.gov/hac.

How Does VA Drug Coverage Interact with Medicare Part D?

VA coverage for prescription drugs is considered creditable, meaning it is as good as, or better than, Medicare Part D. It is possible to have both a Part D plan as well as VA drug coverage. If one chooses to forego Part D and then later wishes to enroll in Part D, there will be no penalty for late enrollment.

For more information on VA benefits, call 1-877-222-8387 or visit www.vba.va.gov.

OTHER HEALTH COVERAGE OPTIONS FOR NEW YORKERS

COBRA

Federal law requires employers with 20 or more employees to offer COBRA as “continuation coverage” of employer-based health care coverage for 18 months after you leave your job. COBRA is designed to bridge the gap until you go on Medicare or take a new job that offers a health care plan. You can qualify for coverage if you retire, leave your job, get laid off, have your work hours cut, or as a result of the death or divorce from your actively working spouse. Election of continued coverage must take place within 60 days of the notification of COBRA rights. Premiums for COBRA are 102% of what the employer and employee together pay for the plan. Your spouse and dependents are also entitled to benefit from your COBRA coverage, which is generally less expensive than individual private coverage.

If you are on COBRA before you become Medicare eligible, COBRA will stop when Medicare starts. If you are already eligible for Medicare and still working, you may elect COBRA when you stop working, but should enroll in Part B within 8 months of starting COBRA coverage in order to avoid Medicare’s late enrollment penalty.

******You Might Be Able to Purchase COBRA at a Reduced Cost******

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions under the COBRA program. Individuals who were involuntarily terminated from employment between September 1, 2008- May 31, 2010 may be eligible to pay **only 35 percent** of their COBRA premiums for nine months; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. Subsequent legislation expanded the subsidy to those terminated through May 31, 2010 and increased the length of the subsidy from 9 to 15 months. This period will most likely be extended.

Individuals with incomes over \$125,000 (\$250,000 for married couples) are not eligible for this subsidy. In addition, if you are eligible for other group health coverage (such as through a current employer or a spouse’s employer) or Medicare, you are not eligible for this subsidy.

Family Health Plus

Family Health Plus (FHP) is a public insurance program for adults between the ages of 19 and 65 who are without health insurance, ineligible for Medicare or Medicaid, and who have limited or no other health insurance coverage. FHP coverage is available only through private HMOs. Some services covered by FHP include:

- Physician services
- Prescription drugs
- Diabetic supplies & equipment
- Chemotherapy, radiation & dialysis
- Inpatient & outpatient coverage
- Vision, speech & hearing services
- Durable medical equipment
- Dental services
- Lab tests & x rays
- Emergency & ambulance coverage
- Drug, alcohol & mental health
- Rehabilitation services

Eligibility:

- You must be a U.S. citizen or be a qualified alien under one of several categories.
- You must be a resident of New York State.
- You must be at least 19 years old, but under age 65.
- Income limits: Up to 100% of the Federal Poverty Level (FPL) for singles and couples without children under age 19 (up to \$903 per month for a single person and up to \$1,215 per month for couples in 2010). Adults caring for children under age 19 can have incomes up to 150% FPL, for example \$1,822 for a household of 2, \$2,289 for a family of 3 and \$2,757 for a family of 4 in 2010.
- The resource (asset) test has been eliminated for all Family Health Plus applicants/recipients.

There are no monthly premiums or deductibles for Family Health Plus. Co-pays apply for some FHP beneficiaries for some services; providers cannot deny you care if you cannot pay the co-pays. You can apply for FHP at the local Medicaid office or through a community-based facilitated enroller. Contact the Family Health Plus program at 1-877-934-7587 for the location of your nearest Medicaid office or facilitated enroller for applications and application assistance. Visit www.health.state.ny.us/nysdoh/fhplus for more information.

Households with children under age 19 who are uninsured may wish to explore **Child Health Plus (CHP)**. Through CHP, children in families with incomes up to 400% FPL (\$7,350/month for a family of four in 2009) can get free or low-cost health insurance. For more information, call 311 and ask for more information on Child Health Plus.

Healthy New York

Healthy New York is reduced cost health insurance for small employers, sole proprietors, and individuals who lost their insurance due to unemployment of self or spouse. Eligibility guidelines for small employers are different than those for individuals and sole proprietors. All Healthy NY coverage is offered through private insurance companies, and monthly premiums vary by plan. Co-payments and deductible amounts are the same for all Healthy NY plans.

For Healthy NY coverage for individuals, one must be between the ages of 19 and 65, and ineligible for Family Health Plus or Medicare. If the individual is covered through COBRA they can apply for Healthy NY instead, or they can apply prior to their COBRA ending. Gross monthly income limits in 2009 are \$2,257 for an individual, \$3,036 for a household of two, \$3,815 for a household of three and \$4,594 for a household of four. There are no resource limits.

For additional eligibility information, and eligibility information for small employers and sole proprietors, as well as application information, please contact 1-866-432-5849 or visit www.healthyny.com.

Health Pass

Health Pass is health insurance for the working uninsured and is available to small businesses and sole proprietors. Coverage is offered through several managed care companies. For additional information, please contact 1-212-252-8010, or visit www.healthpass.com.

HHC Options

HHC Options is a program through the NYC Health and Hospitals Corporation that allows low and moderate income individuals and families to access health care through HHC's network of hospitals and health facilities on a sliding fee scale. There is no charge to participate in HHC Options; you only pay when you access care. HHC does not look at immigration status when determining eligibility. For more information, visit www.nyc.gov/html/hhc/html/access/hhc_options.shtml.

Health Insurance & Self Employment

Some professions offer group rate insurance. Please inquire with your former employer and/or any professional associate memberships to which you belong. Here are a few resources to explore whether or not group plans may be available to you. You may also contact the NYS Association of Insurance & Financial Planners at 1-212-221-3500.

| | | |
|-------------------------------|--|--|
| Small Business Service Bureau | Small business employee | 1-800-343-0939 www.sbsb.com |
| Graphic Artists Guild | Graphic Artists | 1-212-791-3400 www.gag.org |
| National Writers Union | Writers | 1-212-254-0279 www.nwu.org |
| Screen Actors Guild | Performers | 1-212-944-1030 www.sag.org |
| Freelancer's Union | Financial Services Nonprofits Technology Media & Advertising Arts, Culture or Entertainment Domestic Child Care Giver Traditional or Alternative Health Care Provider Skilled Computer User | 1-718-222-1099 www.freelancersunion.org |

PATIENT RIGHTS AND APPEALS FOR MEDICARE BENEFICIARIES

All Medicare beneficiaries are protected by the same rights, whether you are in the original Medicare plan or a Medicare Advantage Plan.

As a Medicare beneficiary, you have the right to:

- Receive all the care necessary for your condition.
- Be fully informed about your medical condition, including treatment options.
- Learn about coverage and possible costs.
- Receive a written discharge plan from the hospital. Any decision made by the hospital or your HMO or PPO to discharge you must be based solely on your medical need and not on any method of payment.
- Appeal written notices denying coverage for services from hospitals, managed care plans (HMOs) or Medicare carriers.
- Ask for all notices in writing. **DO NOT DISREGARD THEM.** Any notice must describe how to appeal decisions.

To appeal a quality of care issue or question a hospital discharge, call the Independent Peer Review Organization, IPRO, at 1-800-331-7767 where trained staff will review your case before noon of the day after the beneficiary receives the notice. If you request immediate review by IPRO, you will not be financially responsible for additional hospital charges until noon of the day following your receipt of IPRO's review decision.

Medicare Advantage enrollees may use the plan's appeals process to appeal an inpatient stay denial or they can contact IPRO by noon of the day after the receipt of the NODMAR (Notice of Discharge and Medicare Appeal Rights). Other denied services may be appealed directly to the plan.

LONG TERM CARE PLANNING

Now that seniors are living longer, many have concerns about how they will manage health care needs and finances as they become less mobile, or in the event of serious health problems. Long-term care—in one's home, in alternative housing or in a nursing facility—should involve planning. An understanding of the options and the kinds of care, and the financing of such care, will help give seniors greater control over these important issues in their later years. The following is an overview, topic by topic, of the long-term care planning and insurance areas of interest and concern.

What is Long-Term Care?

Long-term care is the kind of daily assistance that an older adult may need when dealing with a prolonged physical illness, a disability, or a cognitive impairment (such as Alzheimer's disease) that can leave a person unable to completely care for himself. Long-term care includes care in a nursing facility, as well as help at home with activities of daily living. Long-term care is generally divided into four categories:

1. Skilled Nursing Care: Daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. The care must be ordered by a doctor.
2. Intermediate Care: Occasional nursing and rehabilitative care, which must be based on a doctor's orders, which can only be performed by, or under the supervision of, skilled medical personnel.
3. Home Health Care: Usually received at home as part-time skilled nursing care: speech therapy; physical or occupational therapy; part-time services from home health aides or help from homemakers or chore-workers.
4. Custodial Care: Care to help individuals meet personal needs such as walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

What are the different ways that someone can receive care in their community?

At Home with a Family Caregiver

Many older adults prefer to be in their own home with an informal family caregiver. A senior's independence and comfort in familiar surroundings can be maintained by having help with shopping and cooking, transportation to and from doctor's appointments, dressing and bathing, and basic home maintenance and repairs.

At Home with a Community Caregiver

When the older adult's needs are greater than a family member's abilities, or if there is no appropriate family or friend, then a trained community caregiver can provide the needed support. Home health aides can help with the activities of daily living. Also, trained or specialized therapists can provide services.

In an Adult Day Care Facility:

Supervision, as well as regular contact with other seniors, is an important benefit of Adult Day Care, which can include social activities, congregate meals, lectures, moderate exercise programs, and access to case workers.

What can be done in advance of needing home care to improve the home surroundings?

- Evaluate the home setting for accessibility in the event of reduced mobility.
- Install safety aids such as handrails on stairs and in the shower, brighter lights and louder telephone rings.
- Remove or reduce hazards such as loose scatter rugs and long electric cords. Place commonly-used items on low shelves.
- Make room for any needed home health care equipment.
- Determine whether another person, not a member of the family, could be accommodated for nighttime duties.

What are the costs of Long-Term Care?

Costs for health care in New York City are generally higher than in other areas of the state. If the older adult is seeking a home health aide on a private pay basis, various arrangements can be made depending on the hours, level of services and skills required. If the health care provider is assigned to the senior from a Home Care Agency, where costs are paid through Medicare or Medicaid, the fees are set by the agency and the government contractor. Home care is \$15+ per hour for custodial services. Skilled care from therapists or visiting nurses, for example, could cost \$80-\$150 per visit.

Nursing home costs in the New York City area average \$112,000-\$120,000 per year. An older adult requiring a nursing home placement must cover these costs either by paying from personal income and assets, having long-term care insurance or having Medicaid coverage.

Who pays for Long-Term Care?

Medicare

Medicare's coverage for long-term care is strictly limited by "medically necessary," prescribed circumstances. This level of care is usually designed for recuperative purpose or rehabilitation.

Care in the Home is covered by Medicare when:

1. The care needed is *intermittent skilled nursing care*—physical therapy, occupational therapy, or speech therapy, monitoring of condition, changing bandages, giving injections, and checking on equipment. "Intermittent" is defined as less than seven days per week, not to exceed 28 hours in any week. Medicare can approve more hours of care per week, but for a shorter period of time. Typically, Medicare approves on average of 8-12 hours of care per week.

2. The beneficiary is unable to leave his home except with the assistance of another person or a wheelchair, for example.
3. The doctor determines that the beneficiary needs home health care and prescribes a home health plan of treatment.
4. The services are provided by a Certified Home Health Agency (CHHA) participating in Medicare.

Care in a Skilled Nursing Facility is covered by Medicare when:

1. The beneficiary is admitted within thirty days after a minimum 3-day hospital stay.
2. The doctor documents that the patient requires a skilled level of care; custodial care can also be involved.
3. The care is provided in a Medicare-certified skilled nursing facility.
4. The Medicare coverage is for 100 days in a benefit period, with cost-sharing between Medicare and the beneficiary from days 21-100.

Medicare Supplement Insurance (“Medigap”)

Some Medicare supplement insurance policies issued prior to June 1, 2010 may provide coverage for home health services. Effective June 1, 2010, no new Medigap policies cover an at-home recovery benefit. However, for individuals with older Medigap plans, D, G, I and J, their policies may offer such coverage, which provides an at-home recovery benefit which pays up to \$40 per visit, up to \$1,600 per year, for personal care services when Medicare covers skilled home health care after an illness or injury. Personal care includes help with activities of daily living, which includes bathing, dressing, eating, toileting and transferring. In order for the Medigap plan to cover any home health care, the beneficiary must first qualify for skilled home health care under Medicare.

Medicaid

Medicaid is the joint federal/state/city funded program that covers all of the health care and long term care needs of persons with low income and limited assets. To qualify for Medicaid as a senior residing at home in the community, the individual must apply and document financial eligibility, along with other criteria. The home health care benefit under Medicaid is available after the treating doctor prescribes the need for skilled and personal care services which can be provided in the individual's home.

In order for Medicaid to cover the cost of a nursing home stay, the individual must meet the applicable income and resource requirements. Individuals must contribute most of their income to the cost of care, retaining only a modest allowance for personal needs.

Medicaid transfer of asset restrictions: Faced with the prospect of the high costs of long-term care in a nursing home and home care, individuals with accumulated assets sometimes consider a transfer of these assets to family members in order to qualify for Medicaid coverage. A caution: **to be a legitimate transfer**, the senior cannot dictate the family member's use of the funds and the senior, in turn, cannot receive any amount “paid back” from that transfer.

New York State law imposes the following requirements and sanctions if a person transfers assets to become Medicaid-eligible for the purposes of receiving institutional services (note that there is no transfer of asset penalty to receive community Medicaid):

- Transfers to a trust made less than 60 months before you apply for Medicaid will result in a penalty waiting period.
- Beginning in February 2009, Medicaid began increasing the lookback period for all transfers (except into trusts) by one month for each month until February 2011, when the lookback period for all transfers will be 60 months. In February 2010, Medicaid will look at assets transferred 49 months prior to the month of application; in March, the lookback period will be 50 months, etc. If assets were transferred during the applicable lookback period, the applicant will be subject to a penalty period, starting on the date the transfer was made. Medicaid coverage will be refused for the number of months the assets would have paid for care in a nursing home.

Planning Option Eliminates “Surplus Income” for Medicaid Applicants

Disabled individuals of any age with community Medicaid services including home care, adult day care and prescription drug costs can utilize all of their income to pay for living expenses by participating in a **supplemental needs trust**. It is no longer necessary for individuals to contribute their “surplus” or “spenddown” moneys to Medicaid. The pooled-income trust fund, managed by a nonprofit agency, receives the individual's monthly surplus income and redistributes it on behalf of that individual as directed by the individual or their legal representative. Please speak to an eldercare lawyer or a knowledgeable geriatric care manager for further information regarding estate planning and the supplemental needs trust.

Community Spouse Protection: When a husband or wife enters a long-term care facility, the spouse remaining at home is protected from financial impoverishment due to covering the costs of care. Federal and New York State law mandate that the community spouse be allowed to retain the couple's home, car, personal belongings and a sum of money from their joint assets. In 2009 under Medicaid, the community spouse may retain a minimum of \$74,820 and a maximum of \$109,560 in assets and \$2,739 per month in income. However, when both spouses are in a home care situation, the Community Spouse Protection does not apply. When one or both spouses are receiving care at home under the Medicaid program, they are allowed to keep income and resources only at the Medicaid-eligible levels shown on page 53.

By law, states are required to impose estate recovery, which is a claim against the estate of the deceased person, including their home, for what Medicaid paid for the person's at-home or nursing home care. The claim process cannot begin until after the death of the surviving spouse or surviving minor child.

Call 311 for more information

LONG TERM CARE INSURANCE

Long term care insurance pays for some or all expenses related to long term care, including care needed at home, in a nursing home, in a community based setting, and assisted living facilities. Individuals purchase policies to protect income and resources, as well as to maintain independence, financial control, and expand care options.

Long-term care insurance has its benefits and limitations. To make the most informed decision, you must understand the policy's coverage terms. Most long-term care insurance policies pay a fixed dollar amount (for example, a maximum daily benefit of \$100) for each day you qualify to receive the designated level of long-term care. Buying a long-term care insurance policy assures at least partial coverage for nursing home, home care and other types of care.

Long-Term Care Insurance: Policy Limitation Definitions

Insurability: All long term care insurance policies are medically underwritten, so companies have the ability to deny you coverage. However, standards vary from company to company, so if one company denies coverage, another may provide it. Overall, you must purchase long term care insurance before you need to use the policy. If you want to buy the insurance because you need the benefits today, you'll have a hard time getting covered.

Pre-Existing Condition Period: This limits the payment of benefits due to a condition that existed on the effective date of the coverage. The limit can only apply to conditions for which medical advice or treatment was recommended or received from a health professional within the six month period before the effective date of coverage. When you apply for coverage, it's important to disclose all of your medical information truthfully.

Elimination Period or Waiting Period: The period of time (usually 30, 60 or 90 days) during which you need long-term care services, but before the policy benefits begin. You pay for 100% of the cost of services during this period. The longer the elimination period a policy designates, the lower the premium.

Benefit Trigger: The conditions that have to exist in order for the policy-holder to become eligible for benefits. All policies in New York State are based on the policy-holder's inability to carry out a certain number of "activities of daily living" and/or "cognitive impairment." Carefully review how each insurer determines your eligibility, and how the policy defines the benefit triggers.

Long-Term Care Insurance Benefit Definitions

Daily Benefit: Insurance policies generally pay a fixed dollar amount per day. For example, an individual may select a policy that pays a daily benefit of \$200 for nursing home coverage. If the cost of care exceeds your daily benefit amount, you are responsible for the difference. Insurance companies also assign a percentage that the policy will pay for home care services, usually between 50-100% of what the policy will pay for nursing home care. If receiving care at home is important to you, then research the policy's coverage for home care.

Costs vary within the nation and within the state, so doing research for the average cost of care in your area is an important factor to consider. For more information about average nursing home costs in New York, visit www.health.state.ny.us/facilities/nursing/estimated_average_rates.htm.

Length of the Benefit: The number of years (usually 3 years, 5 years or 7-10 years) a policy will cover your long term care needs, beginning at the end of the elimination period. For example, if you begin to use the policy's benefits when you are 70 years old, a 3 year policy will provide the benefits of your policy until you are 73 years old.

Inflation Protection: Inflation protection provides increases to the daily benefit amount that helps offset the expected increases in the costs of long term care services. In New York, if you would like a policy with inflation protection, you have the choice of a policy with automatic inflation or periodic inflation. With automatic inflation, the policy's premium will not increase after you purchase the policy. Inflation protection is incorporated into the policy's premium, and benefits continue to increase throughout the life of the policy. With periodic inflation, the insurance company offers the benefit of inflation protection with an increase in premium every couple of years. Insurance companies are required by New York State law to offer this as an option. Because inflation protection increases the policy's benefits, it also increases the cost of the policy's premium.

Waiver of Premium: You do not pay the policy's premium when you are receiving long term care covered by the policy. Some policies automatically include this provision; other times it must be purchased as a rider at an additional cost.

Non-Forfeiture Benefit: An optional benefit that provides some type of return on the premiums that you have paid should you choose to terminate the policy. This benefit can be added to the policy for an additional premium, which is typically very expensive.

Long-Term Care Insurance Premiums

The individual's age at the time of application is a factor in determining the policy's premium. Other considerations, such as inflation protection, amount of daily benefit or the length of the elimination period, will also affect the premium. Once an individual purchases a long term care insurance policy, the premiums remain the same throughout the length of the policy and do not change based on your health status.

Tax Deductions for Long-Term Care Premiums can be made for policies that are

listed as tax qualified.

A federal tax deduction for long term care insurance is claimed as an itemized medical expense that must exceed 7.5% of your adjusted gross income. Since these premiums can be costly, especially for seniors, it is intended as an incentive for purchasing coverage. Taxpayers can deduct the cost of the policy's premium, up to the maximum, by age:

| | |
|---------------------------------|---------|
| Taxpayer age 40 years and under | \$320 |
| Taxpayer age 41-50 years | \$600 |
| Taxpayer age 51-60 years | \$1,190 |
| Taxpayer age 61-70 years | \$3,180 |
| Taxpayer 71 years or older | \$3,980 |

A New York State Tax Deduction for long term care insurance can be claimed as an above the line tax credits of 20% of the premiums using the IT-249 tax form. Tax form IT-249 can be found at: www.tax.state.ny.us/pdf/2008/killin/inc/it249_2008_fill_in.pdf. Instructions for completing the form can be found at: www.tax.state.ny.us/pdf/2005/inc/it249i_2005.pdf.

Types of Long Term Care Insurance Policies

In New York State, there are two types of long term care insurance policies, 1) traditional, non-partnership private insurance; and 2) insurance sold under the New York State Partnership for Long Term Care. Both types of policies can be purchased through an insurance company, certified agent or through some employers who offer long term care insurance as a benefit.

Traditional, non-partnership private insurance policies offer flexibility and customization of options for long term care benefits with a wide range of price points. Typically, the policies are purchased for a specific number of years and are portable throughout the length of the benefit. However, when the length of benefit is finished, if care is still needed, then the individual has to use his/her own resources to cover care expenses.

The New York State Partnership for Long-Term Care program is designed to assist the residents of New York in planning for the cost of long term care. The partnership program combines private long term care insurance with Medicaid Extended Coverage to provide New Yorkers with a lifetime of long term care benefits. To utilize Medicaid Extended Coverage benefits, the beneficiary must reside in New York State.

Here's how it works: After you purchase a partnership policy and you trigger the start of benefits, you will start to use the private insurance policy just like traditional long term care insurance. However, if you exhaust the private portion of the policy's benefits, you will then be able to use the benefits offered through Extended Medicaid without having to "spend down" resources to qualify for Medicaid coverage. This provision allows the Partnership policyholder to have a lifetime benefit of long term care coverage without

having to spend down all one's resources to qualify for Medicaid; one's own income must be used first before Medicaid pays for services.

More information about New York State Partnership policies can be obtained by calling the Consumer Hotline of the **NYS Partnership for Long-Term Care at 1-888-697-7582** or visiting www.nyspltc.org.

More information on long term care insurance can be found at www.longtermcare.gov and www.planaheadny.com.

ADVANCE DIRECTIVES

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW

You have the right to make your own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatments, you should make these wishes known to your doctor, hospital or other health care providers. You have the right to be told the full nature of your illness, including proposed treatments, any alternative treatments and the risks of these procedures.

You need to speak with your spouse, family members, close friends and your doctor to help you decide whether you want an advance directive. Discuss with them, *in advance*, what your personal directions for your care would be.

An advance directive is a document that states your choices about medical treatment. In New York, there are three kinds of advance directives:

1. A Health Care Proxy allows you to appoint another person to make medical decisions for you should you become unable to make those decisions yourself. The "agent" you select needs to be clear about your wishes for treatment, be available if sudden choices need to be discussed, and agree to accept the responsibility if the situation arises. Typically, your doctor or hospital staff cannot be your "agent."
2. A Living Will allows you to explain your health care wishes and can be used to specify wishes regarding life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state. The document must be signed, dated and witnessed (but not by your doctor or a close relative).
3. A Do Not Resuscitate (DNR) Order allows you to specify that you do not want CPR should your heart or breathing stop.

Advance directives should be available in an emergency. Do not put them in a safe deposit box. Give a copy to each of your doctors and to the family member who might be your "agent." A copy is as good as an original.

More information on advanced directives, as well as relevant forms, is available at www.oag.state.ny.us/bureaus/health_care/pdfs/EOLGUIDE012605.pdf, hospitals and doctors' offices, and from state medical organizations. The forms are free of charge and do not require a lawyer to complete.

MEDICARE FRAUD AND ABUSE

The federal government estimates that billions of dollars--approximately ten percent of the Medicare dollars spent--are lost through fraud, waste and abuse. Medicare beneficiaries are encouraged to be alert to, and report, any suspicious billing charges.

What is Fraud?

Fraud is the act of obtaining, or attempting to obtain, services or payments by fraudulent means—intentionally, willingly and with full knowledge of your actions.

Examples of fraud are:

- Kickbacks, bribes or rebates.
- Using another person's Medicare card or number to obtain services.
- Billing for items or services not actually provided.
- Billing twice for the same service on the same date or different date.
- Billing for non-covered services, such as dental care, routine foot care, hearing services, routine eye exams, etc. and disguising them as covered services.
- Billing both Medicare and another insurer, or Medicare and the patient, in a deliberate attempt to receive payment twice.

What is Abuse?

Abuse can be incidents and practices which may not be fraudulent, but which can result in losses to the Medicare program.

Examples of abuse are:

- Over-utilization of medical and health care services.
- Improper billing practices.
- Increasing charges to Medicare beneficiaries but not other patients.
- Not adjusting accounts when errors are found.
- Routinely waiving the 20% co-insurance and deductibles.

Medicare Do's and Don'ts

- **Never** give your Medicare number to people you don't know.
- **Beware** of private health plans, doctors and suppliers who use unsolicited telephone calls and door-to-door selling as a way to sell you goods and services.
- **Be suspicious** of people who call and identify themselves as being from Medicare. Medicare **does not** call beneficiaries and **does not** make house calls.
- **Be alert** to companies that offer free giveaways in exchange for your Medicare number.
- **Watch** for home health care providers that offer non-medical transportation services or housekeeping as Medicare-approved services.
- **Be suspicious** of people who claim to know ways to get Medicare to pay for a service that is not covered.
- **Keep a record** of your doctor visits and the processing of your bills by comparing the Medicare Summary Notice (MSN) and other coverage to the actual care.

Be alert to:

- Duplicate payments for the same service.
- Services that you do not recall receiving.
- Services billed that are different from the services received.
- Medicare payment for a service for which you already paid the provider.

How to Report Medicare Fraud

If you believe health care fraud or abuse has been committed, call 1-877-678-4697. Detail as much of the following information as possible:

- Provider or company name and any identifying number next to his or her name.
- Your name, address and telephone number.
- Date of service.
- Type of service or item claimed.
- Amount approved and paid by Medicare.
- Date of the Medicare Summary Notice (MSN).
- A brief statement outlining the problem. Try to be as specific as possible. When Medicare beneficiaries assist Medicare in finding fraudulent or abusive practices, you are saving Medicare —and yourself—money.

To report Medicare Fraud and Abuse,

Call SMP (Senior Medicare Patrol) at 1-877-678-4697.

To report Fraud & Abuse with Medicare Part D plans,

Call Medic at 1-877-7SafeRx

Fraud and Abuse Are Everyone's Problem and Everyone Can Help!

IDENTITY THEFT

The Federal Trade Commission offers information about how to protect your identity. Please contact the FTC for information or to make a complaint by calling

1-877-438-4338 or www.consumer.gov/idtheft

Please protect your Medicare number and Social Security number, as well as your date of birth, and any other personal information such as banking or credit card information. Be scrupulous and ask questions of those requesting this information from you and do not hesitate to inquire the legitimacy of their need for this information. Be an informed and proactive consumer.

MEDICARE 2010

ORIGINAL MEDICARE DEDUCTIBLES, CO-INSURANCE & PREMIUM AMOUNTS

Part A--Hospital Insurance

| | | |
|-------------------------------------|---|--|
| Deductible | — | \$1,100 (per benefit period) |
| Co-payment | — | \$275 per day for the 61st-90 th day each benefit period — \$550 per day for each "lifetime reserve day" |
| Skilled Nursing Facility Co-payment | — | \$137.50 per day for the 21st-100 th day each benefit period |

Part B--Medical Insurance

| | | |
|-------------------|---|---|
| Monthly Premium | — | \$110.50 |
| Annual Deductible | — | \$155 |
| Co-Insurance | — | 20% for most services; 45% for mental health services |

Note: Some people 65 or older do not meet the SSA requirements for **premium-free Hospital Insurance (Part A)**. If you are in this category, you can get Part A by paying a monthly premium. This is called "premium hospital insurance." If you have less than 30 quarters of Social Security coverage, your Part A premium will be \$461 a month. If you have 30 to 39 quarters of Social Security coverage, your Part A premium will be \$254 per month. These are the Part A premium amounts through December 31, 2010.

Medicare Savings Programs for Low-Income Medicare Beneficiaries (2009)

| | Monthly Income Limit (after any deductions/exclusions) | |
|--|---|---------|
| | Individual | Couple |
| QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co-insurance for those who are automatically eligible for Part A. | \$903* | \$1,214 |
| SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only. | \$1,083 | \$1,457 |
| QI - Qualifying Individuals State pays Medicare Part B premium only. | \$1,218 | \$1,639 |

*You can also apply for QMB if you earn less than the above ranges but are not interested in applying for Medicaid.

MEDICAID 2010

HIICAP/NYC/DFTA

Standard Medicaid

Maximum Income and Asset Levels* for those who are blind, disabled or age 65 and over:

| | <u>Monthly Income</u> | <u>Assets</u> |
|------------|-----------------------|---------------|
| Individual | \$767 | \$13,800 |
| Couple | \$1,117 | \$20,100 |

**First \$20 of income is exempt. Above figures are prior to the \$20 disregard. You are permitted a burial fund allowance of \$1,500 per person.*

Nursing Home-Based Medicaid

INCOME: When a nursing home resident qualifies for Medicaid support, all income goes to the nursing home except for \$50 monthly allowance for the resident's personal needs.

ASSETS: All personal assets must be used up first to meet costs (excluding: primary residence, automobile and personal possessions).

MARRIED COUPLES: When one spouse in a married couple qualifies for Medicaid support in a nursing home, the community spouse (the one remaining at home) is entitled to retain some income and resources belonging to the couple while Medicaid pays towards the residential spousal care.

The community spouse is allowed:

Resources: \$74,820 minimum; \$109,560 maximum **Income:** \$2,739 monthly

In NYC, the Medicaid payment rate is \$9,636 a month towards the care of a nursing home resident.

Medicare Savings Programs for Low-Income Medicare Beneficiaries (2009)

| | Monthly Income Limit (after any deductions/exclusions) | |
|--|---|---------------|
| | Individual | Couple |
| QMB - Qualified Medicare Beneficiary NY State pays premiums, deductibles and co-insurance for those who are automatically eligible for Part A. | \$903* | \$1,214 |
| SLMB - Specified Low-Income Medicare Beneficiary Levels State pays Medicare Part B premium only. | \$1,083 | \$1,457 |
| QI - Qualifying Individuals State pays Medicare Part B premium only. | \$1,218 | \$1,639 |

**You can also apply for QMB if you earn less than the above ranges but are not interested in applying for Medicaid.*

RESOURCES

| | |
|---|------------------|
| NYC HIICAP Helpline..... | 311 |
| www.nyc.gov/html/dfta/html/senior/hiicap.shtml | |
| Department for the Aging..... | 311 |
| www.nyc.gov/html/dfta/html/home/home.shtml | |
| AARP..... | 1-212-758-1411 |
| www.aarp.org | |
| Access-A-Ride..... | 1-877-337-2017 |
| www.mta.info/mta/ada/paratransit.htm | |
| Advocacy, Counseling and Entitlement Services Project (ACES)..... | 1-212-614-5552 |
| Attorney General Bureau of Consumer Fraud and Protection..... | 1-800-771-7755 |
| www.oag.state.ny.us | |
| Catholic Charities of NY..... | 1-212-371-1000 |
| www.catholiccharitiesny.org | |
| Center for the Independence of the Disabled in New York..... | 1-212-674-2300 |
| www.cidny.org | |
| Centers for Medicare and Medicaid Services (CMS)..... | 1-800-MEDICARE |
| www.cms.gov | |
| Child Health Plus..... | 1-800-698-4543 |
| http://www.health.state.ny.us/nysdoh/chplus/index.htm | |
| Community Service Society of NY..... | 1-212-254-8900 |
| www.cssny.org | |
| Eldercare Locator..... | 1-800-677-1116 |
| www.eldercare.gov | |
| Elderly Pharmaceutical Insurance Coverage (EPIC)..... | 1-800-332-3742 |
| www.health.state.ny.us/health_care/epic/index.htm | |
| Family Health Plus..... | 1-877-934-7587 |
| www.health.state.ny.us/nysdoh/fhplus/what_is_fhp.htm | |
| Federation of Protestant Welfare Agencies..... | 1-212-777-4800 |
| www.fpwa.org | |
| Health Pass..... | 1-888-313-7277 |
| www.healthpass.com | |
| Healthy NY..... | 1-866-HEALTHY NY |
| www.healthyny.com | |
| HEAR NOW (provides hearing aids to people with limited resources)... | 1-800-648-4327 |
| www.sotheworldmayhear.org/hearnow/ | |
| Health and Hospitals Corporation (HHC Options)..... | 311 |
| http://www.nyc.gov/html/hhc/html/access/hhc_options.shtml | |
| HRA info line – for all HRA programs, including Food Stamps, Public Assistance and Medicaid..... | 1-877-472-8411 |
| Hospice Foundation of America..... | 1-800-854-3402 |
| www.hospicefoundation.org | |
| Institute for the Puerto Rican/Hispanic Elderly..... | 1-212-677-4181 |
| www.iprhe.org | |
| IPRO (inpatient-quality of care complaints)..... | 1-800-331-7767 |

| | |
|--|--------------------|
| IPRO (to appeal hospital discharge)..... | 1-800-446-2447 |
| www.ipro.org | |
| LawHelp.org (to search for legal services, including pro bono) | |
| www.lsnyc.org | |
| Long Term Care Insurance Resource Center..... | 1-212-676-0629 |
| Medicaid hospital discharge appeals (IPRO) | 1-800-648-4776 |
| Medicaid referral for providers accepting Medicaid..... | 1-800-541-2831 |
| Medicare Coordination of Benefits..... | 1-800-999-1118 |
| Medicare Fraud Hotline (Office of the Inspector General, DHHS)..... | 1-800-447-8477 |
| Medicare Hotline..... | 1-800-MEDICARE |
| Medicare Rights Center..... | 1-800-333-4114 |
| www.medicarerights.org | |
| National Council on Aging | |
| www.ncoa.org | |
| National Health Information Center..... | 1-800-336-4797 |
| www.health.gov/nhic | |
| New York Prescription Saver Card..... | 1-800-788-6917 |
| https://nyprescriptionsaver.fhsc.com | TTY 1-800-290-9138 |
| NYC Department of Health..... | 311 |
| www.nyc.gov/html/doh/htm | |
| NYC Long Term Care Ombudsman Program..... | 1-212-962-2720 |
| www.nyfsc.org/services/ombuds.html | |
| NYS Department of Health-HMO complaints..... | 1-800-206-8125 |
| NYS Insurance Department..... | 1-800-342-3736 |
| www.ins.state.ny.us | |
| NYS Insurance Department (in New York City)..... | 1-212-480-6400 |
| NYS Medicaid Helpline..... | 1-800-541-2831 |
| www.nyhealth.gov/health_care/medicaid | |
| NYS Office for the Aging Senior Citizen Helpline..... | 1-800-342-9871 |
| www.aging.ny.gov | |
| NYS Office of Professional Medical Conduct (physician quality control complaints)..... | 1-800-663-6114 |
| NYU Dental Clinic..... | 1-800-998-9800 |
| www.nyu.edu/dental | |
| Railroad Retirement Information..... | 1-800-833-4455 |
| www.rrb.gov | |
| SMP (formerly Senior Medicare Patrol) in NYS..... | 1-877-678-4697 |
| Social Security Administration..... | 1-800-772-1213 |
| www.socialsecurity.gov | TTY 1-800-325-0778 |
| United Jewish Communities..... | 1-212-284-6500 |
| www.ujc.org | |
| United States Department of Veterans Affairs..... | 1-800-827-1000 |
| www.va.gov | |

Resources for Free or Low Cost Prescription Medications

RX Hope – Apply for discounted and free medications directly through this website.
www.rxhope.com or 1-877-979-4673

Partnership for Prescription Assistance - Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co-payments.
www.pparx.org or 1-888-4PPA-NOW

Benefits Check Up – Helps people locate benefits and services available to them.
www.benefitscheckup.org

NeedyMeds.com – Provides information on medications and patient programs explaining how to apply to each one.
www.needymeds.com

National Association of Boards of Pharmacies (NABP) – Allows you to search for internet pharmacies that are certified as safe distributors.
www.nabp.net

Together Rx Access – A prescription drug discount card available to people whose incomes meet the guidelines and who are not on Medicare and have no prescription drug coverage.
www.togetherrxaccess.com

National Organization for Rare Diseases (NORD) – Helps uninsured or underinsured individuals with certain health conditions to access needed medications.
www.rarediseases.org/programs/medication

Other Internet Resources

Department of Labor - Information on COBRA, Black Lung, etc. – www.DOL.gov

Dental Plan Comparison – www.dentalplans.com

Health and Human Services Administration – www.hhs.gov

HealthFinder.gov – Access information specific to different health conditions

Families USA – Information on health care policy – www.familiesusa.org

Kaiser Family Network - Information on health care policy – www.kaisernetwork.org

National Health Policy Forum – www.nhpf.org

A senior-specific portal to information geared specifically to seniors – www.seniors.gov

Medicaid Offices in New York City

Medicaid applicants can call the Medicaid Helpline at (888) 692-6116 to find the nearest Medicaid office, office hours and directions. New York City residents can apply at any office in the five boroughs.

Citywide Medicaid Office:

Central Medicaid Office, 340A West 34th Street. New York, NY 10001

Manhattan

Harlem Hospital: 530 Lenox Avenue (Ron Brown Building), First Floor, Room 1061 (Use the 137th Street entrance). (212) 939-8504.

Bellevue Hospital: 462 First Avenue & 27th Street, Admin. Bldg "G" Link, 1st Fl. (212) 679-7424.

Metropolitan Hospital: 1901 First Avenue, 1st Floor, Room 1D-27 (97th Street & 2nd Ave. entrance). (212) 423-7006.

Columbia-Presbyterian Hospital: 622 West 168th Street, 1st Floor, PH 040. (212) 342-5102/5103.

Gouverneur Hospital: 227 Madison Street, 7th Floor. (212) 238-7790.

Bronx

Lincoln Hospital: 234 East 149th Street, Basement, Room B-75. (718) 585-7872/7920.

North Central Bronx Hospital: 3424 Kossuth Avenue, 1st Floor, Room 1A05. (718) 920-1070.

Morrisania Diagnostic & Treatment Center: 1225 Gerard Avenue, Basement. (718) 960-2752/2799.

Bronx Lebanon Hospital: 1316 Fulton Avenue, 1st Floor. (718) 860-4634/4635.

Brooklyn

Boreum Hill Medicaid Office: 35 Fourth Avenue. (718) 623-7427/7428.

Coney Island Medicaid Office: 30-50 West 21st Street. (718) 333-3000/3001.

Woodhull Hospital: 760 Broadway, Ground Floor. (718) 630-3397/3398.

East New York Diagnostic and Treatment Center: 2094 Pitkin Avenue, Basement. (718) 922-8292/8293.

Kings County Hospital: 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor. (718) 221-2300/2301.

Queens

Jamaica Medicaid Office: 165-08 88th Avenue, 6th floor. (718) 523-5699

Far Rockaway Medicaid Office: 219 Beach 59th Street, 2nd floor. (718) 634-6910

Elmhurst Hospital Medicaid Office: 79-01 Broadway, Room D4-17. (718) 476-5904

Staten Island

Staten Island Medicaid Office: 215 Bay Street. (718) 420-4660/4732

NOTES