

Health Benefits



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Understanding Your Medical Benefits

Health Insurance Counseling

HIICAP

(Health Insurance Information Counseling and Assistance Program)

(315) 435-2362

HIICAP counseling provides Medicare beneficiaries, their representatives, and people planning to retire with free unbiased information and assistance relating to health insurance. This is a free and confidential service offered by volunteers trained by the Onondaga County Department of Aging & Youth. HIICAP Counselors can also help consumers understand their medical bills and health insurance policies; provide information on Long Term Care Insurance, Medicare, Supplemental Insurance, and Medicare Managed Care. Call (315) 435-2362 to arrange for a free, convenient appointment.

Medicare is a federal health insurance program for people age 65 and older, certain

Solutions

Syracuse Jewish Family Service
4101 East Genesee Street
Syracuse, NY 13214
(315) 445-0820

Office Hours: Monday, Tuesday, Thursday 9:00 a.m. to 5:00 p.m.; Wednesday 9:00 a.m. to 9:00 p.m.
Friday 9:00 a.m. to 4:00 p.m.

Solutions will organize monthly bills for payment and write checks if needed; prepare and make deposits and balance monthly bank statements; keep accurate records to assist you and your accountant in preparing tax returns; arrange for professional accounting or legal advice when needed; prepare insurance forms to submit for payment; follow up on problem claims; assist with Medicaid, SSI, Social Security Disability applications, and more. Non-sectarian service. Fee.

Long Term Care Insurance

While every long term care insurance product has a 30-day “free look” period where you can change your mind and get a full refund, it is best to make a wise decision regarding one of the most important investments you will ever make.

The checklist below will guide you in making your own decisions regarding which policy may be best for you. It is always a good idea to meet with a professional who is objective and understands your needs and priorities to assist you in making this decision.

Your Personal Checklist

Underlined items will impact the total cost of your LTC policy. Answer these questions for each policy you’re considering to compare features and choose the one that best suits your needs.

What services are covered?

- Nursing home
- Assisted living
- Home health care
- Day care
- Homemaker services
- Respite
- Informal caregivers
- Other _____

What is the policy’s daily benefit?

Nursing home \$ _____
Home care \$ _____

How long will the benefits last?

Nursing home _____

Defining Policy Terms

Wading through long term care insurance policy features and keeping all the terminology straight can be a daunting task. To help you through the process of shopping for a policy we’ve defined some commonly used terms here.

Daily Benefits

Amount of money the policy will pay each day for nursing home and home care costs.

Elimination Period

Waiting period before your benefits begin.

Is there a maximum lifetime benefit?

Nursing home \$ _____
Home care \$ _____

What is the elimination period?

Nursing home _____
Home care _____

Is the policy guaranteed renewable?

- Yes
- No

Is there an inflation adjustment feature?

- Simple
- Compound
- On request
- No inflation adjustment

Is there a nonforfeiture benefit?

- Yes
- No

Is there a waiver of premium?

- Yes
- No

How much does the policy cost?

\$ _____

Other policy options and cost

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Guaranteed Renewable

A policy that cannot be canceled for any reason - even in the case of infirmity, old age, disability, etc. - as long as you pay your premiums and are truthful on the initial application.

Inflation Adjustment

Ensures that your benefits will keep pace with rising costs of health care and inflation.

Maximum Lifetime Benefit

Total amount of money available to cover costs throughout the policy's term.

Nonforfeiture Benefit

Provides a cash value which is a percentage of the sum of premiums paid by you if you decide to discontinue your coverage.

Waiver of Premium

Allows you to stop paying premiums while you are receiving benefits.

Courtesy of CNY Elderplanning



Policy Shopping Tips

- Research several companies to compare benefits and prices, which can differ dramatically.
- Be sure to only do business with stable, established companies and agents.
- Ask your insurance professional whether a "New York State Partnership" plan may be the right plan for you.

Additional Information:

Onondaga County
Department of Aging & Youth
(315) 435-2362

New York State Partnership for Long Term Care Insurance
1-888-697-7582
www.nyspltc.org

A unique program that combines private long-term care insurance and Medicaid to help New Yorkers prepare financially for the possibility of needing nursing home or home care. The program allows New Yorkers to protect their assets while remaining eligible for Medicaid if their long-term care needs exceed the period covered by their private insurance policy. Insurance companies sell the Partnership policies.

Call the state's toll-free hotline for basic questions about the Partnership policies and to find out which insurance companies offer them:

People of middle age and older should consider these policies if they:

- Are generally healthy
- Are married and have a total income of at least \$40,000-\$50,000 and assets, not including the home, of at least \$140,000.
- Are single and have a total income of at least \$30,000 and assets, not including the home, of at least \$60,000.

Medicare

Medicare is a federal health insurance program for people age 65 and older, certain younger disabled people, and people with kidney failure. It is administered by the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services.

Contacts for Medicare Beneficiaries (Hospital Insurance)

Medicare Part A

Empire Medicare Services

P.O. Box 4846

Syracuse, New York 13221-4846

Tel: 1-800-Medicare

www.empiremedicare.com

Medicare Part B (Medical Insurance)

Upstate Medicare Division—Part B

P.O. Box 5200

Binghamton, New York 13902-5200

Tel: 1-800-252-6550

Spanish: 607-766-6223

TTY: 607-766-6260

www.umd.nycpic.com

Medicare Eligibility

You are eligible for Medicare if any of the following statements are true:

- You are 65 or older and you or your spouse receive benefits under the Social Security or Railroad Retirement system; or
- You have been disabled under Social Security or the Railroad Retirement Board for more than 24 months; or
- You receive continuing dialysis for permanent kidney failure, or you have had a kidney transplant.

Medicare Enrollment

If you are already receiving Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically be enrolled in both Medicare Part A and Part B. You will also be automatically enrolled after you have been disabled under Social Security or Railroad Retirement for 24 months. A card will be mailed to you about three months before you are entitled to Medicare. If you do not want Part B, follow the instructions on the card. Contact your Social Security Office at 800-772-1213.

If you are not receiving Social Security or Railroad Retirement Benefits you need to apply for Medicare three months before you turn 65. That is the beginning of your seven-month initial enrollment period. You will also need to apply if you require regular dialysis or a kidney transplant.

If you do not enroll in Medicare Part B during your initial enrollment period, you will have to wait to enroll until the next general enrollment period. A general enrollment period is held each year from January 1 through March 31. Part B coverage starts the following July.

Premiums for Part B generally will be higher if you wait to enroll during a general enrollment period. The Part B premium goes up 10% for each 12 months after you were first eligible to buy it. So, if you wait to enroll in Part B, your premium will always be higher.

In some cases you can delay enrolling in Part B without having to pay higher premiums. Specifically, if you are 65 or over and have group health insurance based on you or your spouse's current employment, or if you are disabled and have group insurance based on your or any family member's current employment, you have a choice as to when to enroll. You may enroll while you are covered by the group plan or you can enroll during a special 8-month enrollment period that begins the month you or your spouse stop working or when you are no longer covered under the employer plan, whichever comes first. If you do not enroll during this period, you will have to wait until Medicare's next general enrollment period.

Even if you continue to work after you turn 65, you should at least sign up for Part A. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be a good idea to sign up for Part B at the same time. You would have to pay the monthly Part B premium and the Part B benefits would be of limited value to you as long as the employer plan is the primary payer of your medical bills. Contact your benefits office to verify that their health plan will remain primary when you turn 65. Some health plans require the insured to enroll in Medicare Part B when they become eligible. If the insured does not enroll in Part B, the plan will refuse to pay any claims.

Contact your local Social Security office for more information regarding Medicare enrollment or telephone 800-772-1213.

What Medicare Pays

Medicare will pay for care that is "reasonable and necessary" for the treatment of an illness or injury.

Medicare does NOT pay for services that are "routine or custodial" or "inpatient care that could be provided by persons without professional skills/training."

The Medicare program never pre-authorizes payment of services. All services determined to be a "covered" service by law are still subject to the "reasonable and necessary" clause.

Medical beneficiaries traveling outside the United States should inquire about special short-term health insurance or travel insurance for foreign travel.

Payment for medical services received by a beneficiary is contingent upon those services being rendered or provided by a medical professional or institution which has been certified by Medicare. For this reason, it is general policy that the program is in effect only within the United States and its territories.

Certain limited coverage is available in Canada and Mexico if the beneficiary is traveling between two United States sites. Coverage of foreign claims in Canada and Mexico is also limited to emergencies in which the beneficiary is unable to return to the United States to receive treatment.

Medicare Part A-Hospital Insurance

Medicare Part A is referred to in Title XVIII of the Social Security Act as “Hospital Insurance.”

It contains four major benefits:

- Hospital Inpatient
- Skilled Nursing Facility (SNF) Inpatient
- Home Health
- Hospice

It is interesting to note that even though this is known as the “hospital benefit,” only one of the provisions is actually rendered in the hospital.

Part A “Hospital Insurance” only covers an overnight inpatient admission. Part A does not cover outpatient hospital services (this is covered By Part B); nor does it cover any of the professional fees of physicians, radiologists, anesthesiologists, etc., who may see a patient during an inpatient stay.

Benefit Periods

Coverage for care in hospitals and skilled nursing facilities is measured in “benefit periods.” In each benefit period, you are limited as to the number of days Medicare will help pay for inpatient hospital and skilled nursing facility care. Once you exceed the limit, you are responsible for all charges for each additional day of care.

A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 straight days, including the day of discharge. It also ends if you stay in a skilled nursing facility without receiving skilled nursing care for 60 straight days.

Once you have ended one benefit period, a new benefit period begins and your hospital and skilled nursing facility benefits are renewed. There is no limit to the number of benefit periods you can have.

Medicare Part B

Medicare Part B is the medical insurance portion of the Medicare Program that covers the following services.

Ambulance services	Durable medical equipment
Flu shots	Laboratory tests
Medical diagnostic tests	Outpatient hospital care
Physician services	Routine pap smears
Screening mammography	Various medical services and supplies

How Do I File My Claims?

Providers enrolled in the Medicare Part B program fall into two categories, participating and nonparticipating. Both providers are required to file all claims to Medicare for the patient.

Participating Providers:

Many doctors have signed agreements with Medicare to become Medicare participating physicians. Participating physicians have agreed in advance to **always** accept assignment for Medicare claims.

When your doctor accepts assignment, he/she agrees to accept the Medicare approved amount for Medicare covered services as payment in full. For most services, Medicare will pay 80% of the approved amount to the doctor. You will owe the doctor the remaining 20%. (Some supplementary or Medigap policies will pay part or all of this amount.)

Nonparticipating Providers:

When your doctor does **not** accept assignment, Medicare will still pay 80% of the approved amount. The check will be sent to you instead of the doctor.

On non-assigned claims, a doctor may charge more than the Medicare approved amount. Federal law limits what a doctor can charge to 15% over the Medicare approved amount. New York has stricter guidelines for limiting charges. New York State sets this limit at 5% over the Medicare approved amount. You will be responsible for paying the remaining 20% plus any extra amount up to the limiting charge.

Even if your doctor is not a participating physician, he/she may still accept assignment for Medicare claims. Ask in advance if assignment will be accepted.

If you believe you have been overcharged or have a Part B question contact Upstate Medicare Division, PO Box 5211, Binghamton, New York 13902-5211. Telephone number 800-252-6550.

Annual Deductible

The Medicare Part B deductible is currently \$100 per calendar year and is your responsibility. The deductible is met from what Medicare allows for the services you received. Some supplemental or Medigap insurance policies cover the Part B deductible. If you are not sure if your policy will cover the Medicare Part B deductible contact your supplemental insurance company at the customer service number on the back of your insurance card.

The Part B deductible is not met by the actual charge billed by your doctor or by services not covered by Medicare. The deductible is applied to a claim based on the date it is received, not the date the service was provided to you.

A provider may ask you to pay a portion of your Medicare Part B deductible at the time a service is rendered. A provider may only ask you to pay the Medicare allowed amount for the services you received that day. The doctor should indicate the amount you paid on the claim submitted to Medicare.

Note: The Part B deductible will not apply to flu or pneumonia shots, screening mammograms, pelvic examinations, or clinical laboratory testing including, screening pap smears.

Co-insurance

After your \$100 Medicare deductible has been met, Medicare Part B will generally pay 80% of the Medicare allowed amount for covered services you receive within the remainder of that calendar year. You are responsible for the remaining 20% known as the co-insurance.

Exceptions:

- Outpatient psychiatric services are reimbursed at 50% of the Medicare approved charge. You will be responsible for the remaining 50% co-insurance.
- Medicare Part B pays 100% of the Medicare approved charge for clinical laboratory testing, and the flu and pneumonia vaccines.

All Medigap supplemental insurance plans and some secondary insurance policies cover the Part B co-insurance. If you are not sure if your policy will cover the Medicare Part B co-insurance, contact your insurance company.

What is MSP?

Sometimes other insurers should pay your medical bills before Medicare pays its share. This is called coordination of benefits by most insurers. Medicare calls it Medicare Secondary Payer.

Medicare and Other Insurance

Coordination of benefits where another insurer could have a primary payment responsibility.

- Working Aged (EGHP)
- Disability
- End Stage Renal Disease 'ESRD' (EGHP)
- Workers Compensation (WA)
- Veterans Administration (VA)
- Black Lung (BL)
- Automobile No-fault
- Liability

Under the managed care delivery system, you choose a primary physician who refers you to specialists when necessary. Managed care organizations contract with individual providers, set policies and control costs. Each managed care plan has its own hospitals, nursing facilities, doctors, suppliers and other health care professionals. You make a co-payment after office visits.

Medicare Managed Care is health insurance for people who are eligible for Medicare. In this system, the federal Medicare program pays a health maintenance organization (HMO) a fixed amount per member. When you choose a plan, it is important to ask whether the plan has a "risk" contract or a "cost" contract with Medicare.

Under a "risk" contract the HMO receives a fixed amount of money from the federal Medicare program, which it must use to provide quality medical care to its members. The HMO may also charge additional premiums. Your medical care is covered only if you use the HMO's approved doctors and suppliers, except for emergency care.

When an HMO has a "cost" contract, members use health services within the plan, but Medicare also pays its share for the services of providers outside the plan. Members are responsible for co-insurance, deductibles and any other charges as in traditional fee-for-service Medicare. This may be an appropriate choice if you travel often or live in another state part of the year.

Managed Care

Both “risk” and “cost” plans provide all of the Medicare benefits generally available in the plan’s service area and may also offer extra benefits not covered by fee-for-service Medicare.

Questions to Ask when Considering a Managed Care Plan

Your Doctor

- Can I choose my primary care physician? How do I do this?
- On average, how long will I have to wait for a routine care appointment? If I am ill?
- If I have a chronic illness, will I be required to get repeated referrals to specialists from my primary care physician?
- Will the HMO pay for a second opinion from a doctor outside of the plan?
- Is my doctor receiving financial incentives to keep costs down or to join a specific plan?

Payment

- Does the HMO charge a premium in addition to the Medicare Part B premium?
- What are my co-payments?
- What do I have to pay if I am referred to a doctor outside the plan?
- Will I have to pay if I choose to see a doctor outside the plan?

Benefits

- Does the HMO offer services in addition to those provided by Medicare? If so, what are they?
- Are there any restrictions or caps on coverage?
- Does the HMO offer prescription coverage? If so, is there a co-payment? An annual limit?
- How does the HMO determine the cost of prescription?

Covered Care

- Will I be covered for emergencies or routine care if I become ill while I’m away on vacation?
- Will I be covered if I leave the area for an extended period of time?
- Can I get emergency care without prior authorization from the HMO?

Quality of Care/Appeals

- How is the quality of patient care evaluated?
- If my doctor disagrees with an HMO decision, can he appeal?
- If I disagree, what are my appeal rights?

Health Plan Logistics

- Do I need to keep my Medicare supplemental policy?
- Should I give up my company – or union – sponsored retiree health care plan?
- If I give up my retiree plan, will I be able to get it back if I decide to leave the HMO?

Medicare Managed Care Terms

Approved Charge (Amount): The amount Medicare determines is reasonable for a service covered under Part B. It is taken from a fee schedule that assigns a dollar value to all Medicare-covered services.

Assignment: When a doctor or medical equipment supplier accepts the Medicare-approved amount as full payment for services or supplies covered under part B. After annual deductible, Medicare usually pays 80% of approved amount and beneficiary pays 20%.

Ancillary Services: Health services provided during inpatient hospital stay, including: use of operating room, prescription drugs, anesthesia, laboratory, X-ray, respiratory services.

Capitation: Insurance payment mechanism in which a fixed amount is paid per person to cover health services, unlike the traditional payment of a fee for each service provided.

CMP: Competitive Medical Plan. An organization that meets federal government criteria to obtain a Medicare risk contract.

Co-payment (Co-insurance): The insured and insurer share payment of the approved charge for covered medical services after payment of deductible. Under Medicare Part B, the beneficiary pays co-insurance of 20%.

Deductible. The initial amount of medical expense an individual must pay each year before Medicare starts to cover health care costs.

Emergency Care: Health services furnished by a source other than the HMO because of injury or sudden illness when there is no time to reach the HMO's providers or suppliers without risking permanent damage to the patient's health.

HCFA: Health Care Financing Administration. A branch of the federal Department of Health and Human Services that administers Medicare and Medicaid programs.

HMO: Health Maintenance Organization. A managed-care health plan that acts as both insurer and provider of a comprehensive set of health services (hospitalization, preventive care, diagnosis, nursing care) to enrolled members. Benefits are financed by pre-paid premiums with limited co-payments.

Lock-in: when an HMO requires that members use only its network of providers.

Managed Care: Health care service payment or delivery arrangements where the health plan controls and coordinates use of health services by its enrolled members to contain health expenditures and improve quality.

Medicare Part A: Hospital insurance portion of Medicare that provides coverage primarily for inpatient care.

Medicare Part B: Medical insurance portion of Medicare that provides coverage for physicians' services and supplies for the diagnosis and treatment of illness or injury.

Medigap: Private insurance that supplements Medicare coverage, including payment of deductibles, coinsurance, balance bills and services not covered by Medicare. Choice of doctors and/or hospitals is up to the insured.

Out-of-Area: The geographical area outside the boundaries identified by the managed care organization as its service area.

Out-of-Network/Point of Service: An option for members of an HMO to receive certain services outside the plan's established provider network. The HMO determines which services will be offered; annual cost limits and any cost-sharing provisions. Such a plan must make all Medicare-covered services available and accessible in its provider network.

PRO: Peer Review Organization. Paid by the federal government to review hospital treatment of Medicare patients. A patient has the right to appeal to a PRO if there is a question about the quality of care or length of stay.

Pre-existing Condition: Health conditions or problems that were identified and treated before health insurance was purchased, usually within the previous six months. There is a waiting period before new insurance will cover this condition.

PPO: Preferred Providers Organization. A managed health care plan that contracts with networks of physicians and suppliers to furnish services and to be paid on a negotiated fee schedule. There is a financial incentive to use providers on the preferred list, but one may use non-network providers as well.

Primary Care Physician (Gatekeeper): Doctor responsible for coordinating all health care services for the insured by making all decisions about and overseeing the patient's care, including ordering any tests or making referrals to specialists.

Prior Authorization: approval required before a medical service can be provided or covered by the managed care plan. Generally the responsibility of the provider to obtain the authorization.

Provider: Someone who is licensed, certified or authorized to provide contract benefits (services and supplies) including hospital, pharmacy, physician, skilled nursing facility, home health agency, hospice, ambulance or laboratory service to the HMO member.

Service Area: the geographical area that an HMO identifies as the area in which it will provide medical services to its members.

Subscriber: the person who enters into a contract with a managed care organization.

Medicaid

Medicaid Telephone Numbers (not SSI)

Community Case Unit	315-435-2928
Chronic Care – Home Care	315-435-3840

The Medicaid Program, as a separate assistance program, came into effect in 1965. Medicaid is a governmental program designed to pay for the medical expenses of the poor, and increasingly so, for those made poor by large medical bills, typically for hospital or nursing home care. The Federal government requires each state to have a single, statewide Medicaid program. Eligibility standards, benefits, and rates aid to providers are set by the New York State Health Department. Eligibility and benefits are the same throughout the state, provider rates may differ by region. New York State has one of the most comprehensive Medicaid benefit plans in the country.

Local Departments of Social Services are responsible for determining initial and continuing eligibility for Medicaid. The local agency enters the eligibility and demographic data into the New York State Welfare Management System (WMS). This information is then electronically transferred to the Medicaid Management Information System (MMIS). The MMIS system processes the payments to the providers of medical care, through a private fiscal intermediary.

Medicaid is an entitlements program; eligibility is determined by an income and resource test. SSI recipients and children in foster care are automatically eligible for Medicaid, individuals and families receiving Temporary Assistance may receive Medicaid at their request. The Medicaid Only Units are responsible for applications and continuing coverage for all other individuals and families whose income and resources fall within the Medicaid eligibility standards.

There are two Units within the Medicaid Only Division—Community Cases, and Chronic Care – Home Care. Community cases are individuals and families not in need of long term institutional or home care. Chronic Care-Home Care cases are residents of nursing homes, alternate care wards in hospitals, or enrolled in the Personal Care Program, Long Term Home Health Care Program, Assisted Living Programs, Independent Living Services (PACE), Consumer Directed Program, Personal Response program (PERS), or adults receiving home care services for more than 60 continuous days.

What is Medicaid? (From AARP)

Medicaid helps people with low incomes to pay for medical bills. Medicaid is not the same as Medicare. Both programs provide health coverage, but Medicaid provides health coverage for people with limited income of all ages. Each state's Medicaid program is different. In many states if you are eligible for Supplemental Security Income (SSI) you are automatically eligible for Medicaid. To get Medicaid benefits by applying for SSI, call the Social Security Administration at 1-800-772-1213.

Who is Eligible?

Medicaid helps persons of all ages who have low incomes and few resources, and in some cases, people with high medical expenses. Income means the amount of money that you receive each month. Resources mean the items you own.

To be eligible you must meet certain requirements such as:

Income Limit: You must meet the income guidelines. Be sure to take proof of your income when you apply.

Resource Limit: Your resources, such as bank accounts, or money you might have on hand, must be limited. Your home, if you live in it, and one car, and some other items are not counted.

Citizenship: You must be a citizen, or a non-citizen eligible for SSI (this includes veterans, refugees for five years after entry, and those with a ten-year work history). States have the option to provide Medicaid to other legal non-citizens.

Emergency Medicaid is available to everyone.

What Benefits Can You Get from Medicaid?

Medicaid pays for basic health services. Medicaid may also cover some services not covered by Medicare. Some of these are medicine, nursing home care, eye exams, transportation for medical care, glasses, and other medical services. It may also help pay for Medicare. Many states now provide Medicaid health services through managed care plans, such as health maintenance organizations (HMO's).

You should be aware that states have the authority to recover, after your death, the amount of Medicaid spent for nursing home care and other health services from your estate. All states have procedures to waive recovery in hardship cases.

Where Do You Apply for Medicaid?

You may apply for Medicaid at your local Department of Social Services. You must be a resident of the state where you apply.