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SPECIAL SECTION

THE DAILY NEWS GUIDE TO MEDICARE II

COUNTDOWN TO COVERAGE

It's time to decide on your Medicare plan

BY JORDAN GALLOWAY
NEW YORK DAILY NEWS

Health care coverage is a primary concern for millions of Americans. For those 65 and older, there is still time to secure insurance for the year ahead by signing up for a Medicare policy during open enrollment – but you have to act fast because the window for picking a plan is closing quickly.

The Medicare enrollment deadline is Dec. 7, which means undecided seniors still looking for affordable health care in 2017 only have a few weeks left to consider their options.

Navigating the enrollment process, avoiding penalties and making sure you get the most out of your Medicare policy is not easy.

If you feel overwhelmed by the open enrollment process, know you're not alone. Every state offers a Senior Health Insurance Information Program (SHIIP), which are state health insurance counseling programs that are set up to be a resource for people on Medicare who are comparing plans.

New York residents looking for assistance can contact the state Office for the Aging's Health Insurance Information, Counseling and Assistance (HIICAP) program, which provides free information, counseling, assistance and advocacy on Medicare, private health insurance and related health coverage plans.

New Yorkers can call 311 or (212) 341-3978 for more information on in-person or over-the-phone help.

Tricia Neuman, senior vice president of the Kaiser Family Foundation and director of its program on Medicare policy, also suggests using online tools like the plan finder on Medicare.gov as a means of weighing your options.

"It's really the best place to go to compare drug plans," she says. "It's actually a great resource; it's just a bit time consuming."

Help is also available over the phone by calling (800) MEDICARE to have a customer representative compare insurance plans for you and mail you the results.

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DO YOUR HOMEWORK FOR BEST MEDICARE OPTION

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Whether it's in person, online or over the phone, before you start the selection process, you should compile a list of beneficial information that will save you time – and potentially money.

"For some people, it's most important to continue to see a certain doctor, specialist or go to a certain hospital," Neuman says. "If that's the case, then that is information they should bring to the table when they're comparing plans."

Making a list of all current medications you're taking, as well as their doses, is also a good idea. Once that information is organized, one of the first things seniors need to ask themselves is how they want to receive their medical care, says David Lipshutz, managing attorney for the Center for Medicare Advocacy.

"By that I mean, do you want to go to a Medicare Advantage plan, which is one-stop shopping in essence? Or would you rather be able to have a free choice in health care providers and look at potential supplemental insurance, which is the route that people in Original Medicare coverage go?"

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If you opt for a Medicare Advantage Plan, your health insurance, including your primary care, hospitals, specialists and prescription drug coverage, are bundled together within a private health care provider network.

All Medicare Advantage plans offer the same benefits as Original Medicare. Some offer additional benefits like vision, dental or hearing, which Original Medicare does not.

Seniors on Medicare Advantage plans pay one premium, deductible and co-insurance charge for their coverage as long as they receive medical services from providers within their network.

That's opposed to the separate premiums and out-of-pocket expenses of Original Medicare's Part A (inpatient hospital stays, skilled nursing facilities, hospice care and some home health visits); Part B (physicians visits, preventative care services and some home health visits); and Part D (outpatient prescription drugs).

"Don't go by premium alone," Lipshutz advises. "A lot of people will go by the lowest premium plan, but very often a lower premium plan will typically have higher co-sharing costs that it expects from you."

So what questions should seniors consider during open enrollment?

"A number of things can change from year to year," Lipshutz says. "People should be asking: 'How is my plan going to change next year, and is there something that would work better for me?'"

Prescription for trouble

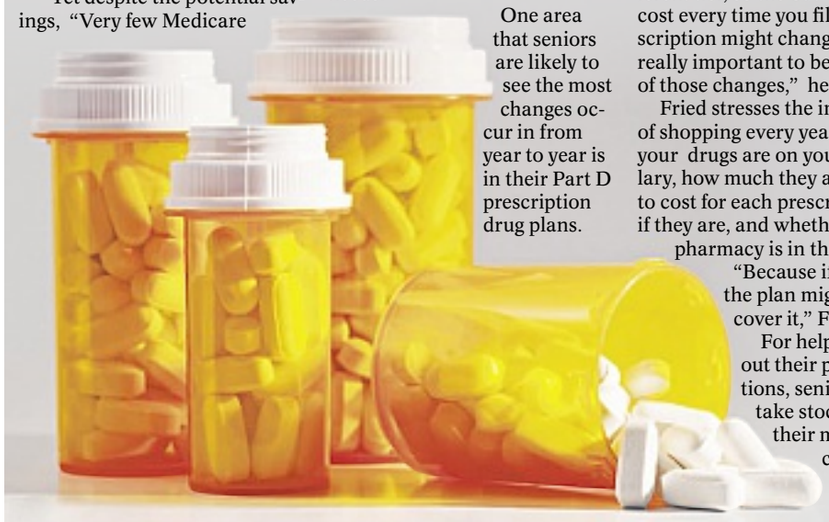
Shop around for a Plan D drug plan to avoid higher costs

BY JORDAN GALLOWAY

Medicare plans change from year to year, and the only way to ensure you're getting the most bang for your buck is by shopping around during open enrollment.

Yet despite the potential savings, "Very few Medicare beneficiaries shop each year," says Leslie Fried, senior director of the Center for Benefits Access at the National Council on Aging.

"It's staggering how low it is, and it's very expensive if they're in a plan that doesn't meet their needs."



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One area that seniors are likely to see the most changes occur in from year to year is in their Part D prescription drug plans.

"What we see during open enrollment is that the drug plans change; the formularies change; the out-of-pocket costs change for premiums and the deductibles change; and the tiers change," Fried says.

"Your drug might be on a different tier, so the out-of-pocket cost every time you fill a prescription might change (and) it's really important to be mindful of those changes," he adds.

Fried stresses the importance of shopping every year to see if your drugs are on your formulary, how much they are going to cost for each prescription if they are, and whether your pharmacy is in the network.

"Because if it's not, the plan might not cover it," Fried said.

For help sorting out their prescriptions, seniors should take stock of their medicine cabinet, compile a list of the prescriptions they're currently taking, and reach out to their local Senior Health Insurance Information Program (SHIIP) for help over the phone or in person.

"There's on average between 25 to 30 prescription drug plans in every state," Fried says. "That's a lot of comparisons and a lot of options, and the differences between out-of-pocket costs over a year are significant – thousands of dollars in differences."

Only seniors enrolled in Original Medicare policies – about two-thirds of all beneficiaries – will be selecting a Part D plan. Prescription drugs are covered under most Medicare Advantage plans as part of their bundle of services.

Supplemental insurance, like Medigap, can help offset the costs of filling prescriptions for seniors with Original Medicare.

Seniors in New York whose income is less than $23,000 (single) or $29,000 (married) could have help paying their Part D premium through the state's low-income subsidy program known as EPIC – Elderly Pharmaceutical Insurance Coverage.

EPIC is open to New York State residents receiving Medicare benefits with an annual income of up to $75,000 (single) or $100,000 (married).

To be eligible, they must be enrolled in a Part D prescription drug plan, either through original Medicare or a Medicare Advantage HMO health plan, and not be receiving full Medicaid benefits. Annual fees are between $3 to $20 based on a sliding income scale.

Besides reducing your out-of-pocket expenses, another perk of the EPIC program is that it allows seniors to sign up for prescription drug coverage year-round, instead of just during open enrollment, and it also includes an annual, one-time Medicare plan change.

Download an application from health.ny.gov, or call (800) 332-3742.

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GUIDE TO MEDICARE

Stay out of the penalty box

Medicare late enrollment fees can add up

BY JORDAN GALLOWAY

While it pays to shop around every year during open enrollment, it's especially important to do so during your first year of eligibility, says David Lipshutz, managing attorney for the Center for Medicare Advocacy.

"When you first become eligible for Medicare, you do have choices to make and there are things you'll want to weigh," he says. "You have certain rights that you might not have down the road."

One of these rights is signing up for Medicare supplemental insurance, commonly called Medigap.

The purpose of a Medigap policy is to offset some of the out-of-pocket expenses not covered under your Original Medicare Plan.

For most people, the Medigap open enrollment period starts the first day of the month in which you are 65 or older and enroll in Medicare Part B for the first time.

It lasts six months, and during that time, an insurance company cannot refuse to sell you any Medigap policy it offers; cannot charge you a higher premium than any other senior on its plan; and cannot delay the start of your coverage.

The exception is if you have a pre-existing condition, for which they can opt to delay coverage for up to six months from the time your Medigap policy goes into effect, if the condition occurred within the six months prior to your enrolling in a plan.

Seniors who don't sign up for supplemental insurance during their initial enrollment period run the risk of having their application denied down the road.

That's because outside of the Medigap open enrollment period, insurance providers are not obligated, except in a limited number of circumstances (like switching from a Medicare Advantage plan to Original Medicare) to accept a beneficiary's application unless they meet their underwriting requirements.

Rules about supplemental insurance enrollment vary from state to state, so it's important for seniors to find out their rights in the state where they reside.

New York offers year-round Medigap enrollment and guidelines for reducing the waiting period for Medigap plans to go into effect for seniors with pre-existing conditions if you had creditable health insurance, with no lapse in coverage, for the 63 days prior to signing up for Medigap.

Even if you're still working when you first become eligible for Medicare – which an increasing number of seniors are – and receiving health insurance through your employer, you're liable to be penalized for not enrolling in Medicare during your initial enrollment period.

Seniors who don't sign up for Medicare when they're initially eligible, but then decide to do so down the road, can incur late-enrollment penalties, which can raise your monthly premium or premiums.

How long you're penalized for not picking a policy is determined by how much time lapses between when you first become eligible and when you actually enroll in a Medicare policy.

The late-enrollment penalty for Part A is a monthly fine of 10% for twice the number of years you could have been enrolled but weren't.

For Part B it's a monthly fine of 10% for each full 12-month period you could have had coverage but didn't enroll.

The penalty for Part D is more complicated than parts A or B. If you go without prescription drug coverage for more than 63 days at any point after your initial enrollment period ends, you'll incur a monthly penalty that's equivalent to 1% for every month you were without coverage, multiplied by the national average monthly prescription drug premium for the year you enroll.

The easiest way to avoid penalties? Enroll in a plan when your Medicare eligibility goes into effect.

Seniors not ready to enroll when they turn 65 can use Medicare assistance resources to determine the most affordable way to enroll and avoid penalties without breaking the bank.

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With a few exceptions, Medigap doesn't actually cover any medical costs directly.

What Medigap does is cover some of the co-payments and deductibles Original Medicare doesn't.

Here's a list of benefits you could receive under any type of Medigap plan:

- Medicare Part B preventive care co-insurance
- Medicare Part B co-payment or co-insurance coverage
- First 3 pints of blood
- Skilled Nursing Facility (SNF) care co-insurance
- Medicare Part A co-insurance hospital costs up to an additional 365 days after Medicare benefits are exhausted
- Part A hospice care co-insurance or co-payment
- Medicare Part A deductible
- Foreign travel emergency coverage (up to plan limits)
- Medicare Part B deductible
- Medicare Part B "excess charges"

There are no other kinds of Medigap benefits available, but keep in mind that Medigap is attached to Original Medicare, which has a multitude of benefits.

Joshua Mellberg

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GUIDE TO MEDICARE

Making sense of Medicare

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Understading Medicare terms and the many differerent plans can get confusing. Here are the essentials you need to know.

Premium: A fee for coverage, usually paid monthly.

Deductible: An amount of the expenses you need to cover before Medicare kicks in.

Co-pay/Co-insurance: The portion of the cost that you'll have to cover for each service or drug.

Part A: This insurance helps pay bills for in-patient care at hospitals and skilled nursing facilities, as well as hospice and some home health care services.

Most people don't have to pay a monthly premium for this coverage since they paid Medicare taxes while working. There is, however, a deductible for hospital stays.

Part B: This insurance helps cover the costs of doctors' services, lab tests, x-rays, mental health care and other medically necessary services.

You can delay enrolling in this coverage if you or your spouse have employee-sponsored health care, depending on the size of the employer.

Make sure to sign up as soon as that employment ends, though, or you may be subject to penalties and have a waiting period before coverage kicks in.

Part C: This isn't additional coverage. Instead, it's an alternative way to get your Medicare benefits.

Also known as Medicare Advantage, these are Medicare-approved plans from private insurers that cover the services included in Parts A and B (which is referred to as "Original" Medicare) as well as prescription drug benefits and sometimes hearing, vision and dental.

Part D: This helps pay for the prescription drugs that you take at home. These are standalone plans through private insurers for people who are getting their Medicare benefits the traditional way — with Parts A and B.

You will likely need to pay a monthly premium, an annual deductible, and co-pays.

Medigap: These are supplemental insurance plans for people using Original Medicare that may cover deductibles, co-pays and other costs.

Medigap plans are standardized and labeled by letters, but they are offered by a variety of private insurers. Your employer or union may already offer you similar coverage, so check before you buy.

Sources: Medicare.gov, Medicare Rights Center, AARP

Stake a claim

Appealing an insurance denial can bring results

BY JORDAN GALLOWAY

Having a claim denied by an insurance provider and then needing to pay for a medical service out-of-pocket isn't cheap.

In fact, the costs could be insurmountable for the majority of Medicare beneficiaries when you consider that a hospital stay or procedure without insurance could be more than they make in a year.

"Half of all people on Medicare live on an income of $24,000 or less per person," says Tricia Neuman, senior vice president of the Kaiser Family Foundation and director of its program on Medicare Policy.

Mistakes happen, but when it comes to submitting an insurance claim, they could really cost you.

There are several reasons a claim could be denied, but three common mistakes are incorrect and/or incomplete patient identifier information; your coverage was terminated; or the medical service was non-covered.

For seniors who find themselves opening a denial letter, Leslie Fried, senior director of the Center for Benefits Access at the National Council on Aging, offers this advice: "I tell people, 'If in doubt, appeal it.'

"The appeals process is difficult and can be confusing. If you have a claim denied, you have the right to appeal," she says. "I always encourage people to file an appeal immediately and get information about what's required regarding the appeals process."

The Medicare appeals process involves five levels of review, and seniors should not be easily deterred if they don't successfully win their appeals in the first or second rounds of review, says David Lipshutz, managing attorney for the Center for Medicare Advocacy.

"At the two lower levels of review there seems to be an increasingly high rate of denials," he says.

"The level where beneficiaries have the best shot is at the third level, the administrative law judge level. However, there's been a tremendous backlog of cases at the ALJ level."

The Center for Medicare Advocacy has been working through the legal system to address these two issues and to streamline the appeals process for beneficiaries.

While it's made inroads, there's still a long ways to go, Lipshutz says.

"We have a lot of concerns about the appeals process. It's supposed to be an avenue to beneficiaries to access coverage when either their provider or the Medicare program disagrees with them. It's an important safety net for beneficiaries in a lot of ways."

While navigating the bureaucratic red tape is time consuming – the average appeal takes about 18 months to complete – your patience could pay off. Over 40% of appeals are awarded fully favorable outcomes, according to the U.S. Department of Health and Human Services.

But for seniors to be successful, they need to beat the clock.

"In the denial notice, there should be information on how to file an appeal, and it's really important to do it in a timely manner and to provide documentation about the medical necessity, whatever the service was," Fried says.

"Each appeals process is different."

The fastest way for seniors to find out if a Medicare claim has been approved or denied is by signing up for My Medicare on medicare.gov, which will alert them to their claim's status 24 hours after it's been processed.

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