MEDICARE PART C

Medicare+Choice: What You Need To Know

Why did Congress overhaul Medicare?

In 1997, Congress passed the Balanced Budget Act, which included steps to help curb Medicare spending and increase its solvency into 2007. These financial measures were made possible by cutting $115 billion from the Medicare program over the next five years and reducing payments to hospitals, managed care plans and other providers.

In addition the act ***established a new Medicare Part C, the Medicare+Choice program***, to provide more coverage options for Medicare-eligible seniors. Plans available under the Medicare+Choice program include new types of managed care plans which go beyond traditional HMOs.

What kind of coverage options are available?

Under the restructured Medicare program, beneficiaries can:

- Remain in traditional fee-for-service Medicare
- Enroll in Medicare HMOs
- Choose from a menu of other coordinated care plans including Preferred Provider Organizations (PPOs), Point of Service Plans (POS) and Provider Sponsored Organizations (see chart for plan definitions).

Key Points of the Medicare+Choice Plans

- Participation in the new Medicare+Choice program is not mandatory. According to the Health Care Financing Administration (HCFA), if beneficiaries are happy with the plan they have, they don't have to do anything.
- Individuals must be enrolled in both Part A and Part B to be eligible for the Medicare+Choice program; these plans are not available to disabled individuals.
- A Medicare+Choice plan is not considered a Medigap insurance policy.
- The sale of a Medicare Supplement policy to a person with an MSA (medical savings account) or a Medicare+Choice private fee-for-service plan is prohibited if it covers expenses that are otherwise required to be counted toward meeting the annual deductible under an MSA plan.

Coverage Options Galore

In addition to the traditional fee-for-service Medicare and current Medicare HMOs, seniors can choose from a variety of plans which include:

MANAGED CARE PLANS

- **PPOs:** Preferred Provider Organizations. Physician networks that provide health services for discounted fees.
- **PSOs:** Provider-Sponsored Organizations. Plans owned by doctors and hospitals that operate much like HMOs.
- **HMOs with POS:** Health Maintenance Organizations with Point of Service option. Arrangements allow enrollees to go out of designated network of doctors for an extra fee.

OTHER PLANS

- **MSAs:** Medical Savings Accounts. Tax-deductible accounts used by beneficiaries to pay for routine medical costs. Paired with high deductible policies to handle big medical bills. Limited availability — Congress authorized only 390,000 to be used.
- **FFS:** Private fee-for-service. Operates like traditional Medicare with differences. Choice of providers and treatment; patients are responsible for whatever costs plan doesn't pay.
- **Private contracts between doctors & beneficiaries:** Doctors and providers contract directly with Medicare beneficiaries; provider is out of the Medicare system for two years; Claims can't be filed with Medicare or Medigap policy; limiting charge doesn't apply.

Sources: The Wall Street Journal, June 5, 1998; *The Indianapolis Star*, June 10, 1998; *The Dallas Morning News*, June 20, 1998; *Medicare and Medicaid Guide*, June 25, 1998; *Consumer Reports*, September 1998.

How will the public be informed of these new changes?

HCFA plans an extensive publicity campaign to explain the new options to beneficiaries. They will also:

- Staff a 1-800 phone number with live customer representatives
- Test a new Medicare handbook, which has been mailed to 5.5 million Medicare beneficiaries in Arizona, Florida, Ohio, Oregon and Washington.
- Mail the remaining 32.5 million beneficiaries a newsletter which outlines the changes to Medicare.
- Allow beneficiaries to obtain information on-line through their new web site, www.medicare.gov

When will these options become available?

- October 1998: Medicare+Choice general information packets mailed to beneficiaries.
- November 1998: Open enrollment period begins. *(Annual open enrollment will be in November of each year beginning in 1999. Enrollments are effective the following January 1.)*
- From 1998 through 2001, beneficiaries can enroll *(if the plan is open to new enrollees)* or disenroll on a monthly basis. For the first six months of 2002 *(or the first six months of eligibility in a year, in the case of newly eligible beneficiaries)*, seniors can enroll and disenroll from plans, but they can only change once during that period.
- January 1, 1999: Options become available. However, beneficiaries will be limited in their coverage options depending upon where they live and what plan types are available in a particular community.

Why do I need to know this?

There is some concern about whether Medicare-eligible seniors are prepared to make an informed decision when selecting health care protection.

- One-third of senior citizens know "little or nothing" about the Medicare+Choice program
- 60% of seniors polled knew nothing about managed care.
- 89% of Medicare beneficiaries in areas of high penetration by managed care don't know enough to make an informed choice between fee-for-service Medicare and HMO-administered Medicare.
- More importantly, your clients will ask you to explain the Medicare+Choice program.

How will Medicare+Choice affect Agents?

What Medicare's new Part C does is allow a few more managed care options, which in the process, creates a lot more confusion for seniors. Comparision shopping is harder for seniors and Part C information coming from HCFA is difficult to use and understand, according to *Consumer Reports*. More choices does not equal better care or better coverage. When Congress cut Medicare, it also decreased its payments to managed care organizations, which in turn cut benefits and raised premiums. And even though the new plan will encourage fiercer managed care competition, it will not alleviate the financial struggles plaguing that industry. The good news for you is Medicare+Choice doesn't change what made fee-for-service an advantage in the first place. UA's Medicare Supplement plans will continue to be an important alternative to meeting seniors' out-of-pocket health care expenses. After all, what seniors really want is insurer stability, freedom of choice and a good doctor-patient relationship. As an Agent marketing Med-Supp insurance, it's important that you understand these new changes to Medicare so you are able to help seniors make an informed decision.