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Tips for Avoiding Marketing Fraud

Have you been hearing more about Medicare private health plans recently? November 15 through December 31 marks the **Annual Coordinated Election Period (ACEP)** and January 1 through March 31 is the **General Enrollment Period**. These periods are the annual set times when people with Medicare can enroll in, disenroll from, or switch to another Medicare private health plan (sometimes known as "[Medicare Advantage](#)" or MA plans), or change to Original Medicare.

Insurance companies work especially hard at [this time of year](#) to enroll people with Medicare into their private health plans. Unfortunately, increased enrollment activity can mean an increase in deceptive enrollment practices. It is important for people with Medicare to understand how Medicare private health plans work and be able to separate fact from fiction when watching TV, reading an ad or listening to a pitch from a sales representative.

What are Medicare private health plans?

[Original Medicare](#) is the Medicare health coverage everyone starts out with, and it is **administered directly through the federal government**. Since it is a not-for-profit system, and the federal government does not make money when you enroll, no salespeople will try to sell you Original Medicare.

Medicare private health plans are **private insurance companies** that contract with the federal government to **provide Medicare health and/or drug benefits**. These private, for-profit companies make money when you enroll, which is why they advertise and employ sales representatives. Types of Medicare private health plans include Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee for Service plans (PFFS), Provider Sponsored Organization (PSOs), Point-of-Service plans (POS plans), Special Needs Plans (SNPs) and Medicare Medical Savings Accounts (MSAs).

When you decide to get your Medicare benefits through a Medicare private health plan, you still have Medicare, and plans must provide **all** Part A and Part B services to you. However, they can do so with additional **rules, costs and restrictions**. They may also offer additional **benefits**, like **vision, dental, and prescription drug coverage**.

A private plan's rules, costs and restrictions can greatly affect how much you pay for care. You may be limited to a **[doctor and hospital network](#)** (and a pharmacy network, if the plan offers Medicare drug coverage—Part D); if you go outside of this network, you will generally be charged the full cost for care (except for emergency or urgently needed care). While doctors and hospitals can drop out of plans' networks at any time, you are limited in when you can change plans. You may be charged more or need to get special permission (known as "prior authorization") for some types of care, generally "specialty" or more expensive care or services.

In a Medicare private health plan you will usually continue to pay the **Part B premium** and you may pay an additional premium. Often, there is no **deductible** for doctors' services, but you may be charged one for hospital care and/or prescriptions. You might pay a set **copayment** (a flat rate, like \$10 or \$15) for doctors' visits, generally with higher copayments for specialty care.

How can you recognize marketing fraud?

Medicare private health plans have to follow certain **[marketing rules](#)**, and when they do not follow them, it is known as **marketing fraud**. Marketing fraud includes advertising false benefits or "special" or "additional" benefits that are simply Medicare-covered services.

Victims of marketing fraud may find themselves unable to see their regular doctor or being billed for services they were told

would be covered. Some people discover they've been enrolled in a plan they had no intention of joining. However, if you can **[recognize marketing fraud](#)** and understand your coverage options, you can make sure you steer clear of these problems and get coverage you need.

How to Avoid Marketing Fraud

5. **Know the Rules.** Recognize the things Medicare private health plans **cannot** do to market their products. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), signed into law in July, added additional restrictions that further protect consumers. By law, plans cannot:
 - **Call you if you did not ask them to do so.** "Cold calling" is not allowed;
 - **Send you unsolicited e-mails.** You must have specifically requested information in order for a plan to e-mail you;
 - **Visit you in your home or nursing home without an invitation.** You can ask the plan to send someone to your house, but they cannot just knock on your door uninvited;
 - **Ask for your financial or personal information if they call you.** Beware if you are asked for your Social Security or Medicare number or your bank information;
 - **Provide gifts or prizes worth more than \$15 to encourage you to enroll.** Gifts or prizes that are worth more than \$15 must be made available to the general public, not just to people with Medicare;
 - **Disregard the National Do-Not-Call Registry and "do not call again" requests.** Plans must comply with federal and state consumer protection laws for telemarketing. You can register online for the National Do-Not-



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Download a copy:

www.medicarerights.org/appealsmanual.html

- **Market their plans at educational events, in health care settings (except for common areas like cafeterias and conference rooms) or where free meals are provided;**
 - **Sell you life insurance or other non-health related products at the same appointment.** This is called “cross selling” and it is prohibited unless you request the non-health related product information;
 - **Compare their plan to another plan by name** in advertising materials;
 - **Include the term “Medicare Endorsed” or suggest that it is a preferred Medicare drug plan.** Plans can use “Medicare” in their names as long as it follows the plan name (for example, the Acme Medicare Plan) and the usage does not suggest Medicare endorses that particular plan above any other Medicare plan;
 - **Imply that they are calling on behalf of Medicare.** Plans are not allowed to give you the impression that Medicare asked them to call you.
2. **Be suspicious.** You should write down and double check everything a sales representative says about coverage and costs. By law, plans and brokers cannot tell you that:
- You must sign up for a Medicare private **health** plan to get Part D drug coverage;
 - You will lose your **Medicaid** benefits unless you sign up for a certain plan;
 - You will pay a higher Medicare Part B premium unless you sign up for a plan;
 - A plan representative must come to your home to give you information or sign you up;
 - The plan offers additional benefits, such as dental or vision, that are actually covered by Medicaid, not the health plan;
 - Certain doctors, hospitals and pharmacies are in the plan's network (when they are not);
 - The plan offers drug coverage through the coverage gap (“doughnut hole”) when it does not;
 - The plan covers certain services (and makes them sound like an additional benefit of the plan, when they are actually Medicare-covered services—like mammogram screenings); or
 - You can always return to Original Medicare if you are dissatisfied with the plan (without advising you about strict enrollment periods when you can change Medicare health and drug plans).

3. **Protect your information.** Safeguard your Medicare number and Social Security number the same way you would protect your credit card number. Only give it out to doctors or health care providers. If you are not ready to sign up for a plan, you do not have to give a sales rep your Medicare number or any other personal information.
4. **Do your homework.** If you keep yourself informed, you make it harder for others to give you misleading information. Learn more about what Medicare covers and whether or not a Medicare private health plan will suit your needs. [Research the plan](#) on your own, and do not take what a sales rep tells you at face value. There are many different plans out there, each with its own set of rules, so consider the following when choosing a plan:
 - Doctor, hospital and pharmacy networks
 - Access to health care
 - Cost
 - Prescription drug coverage
 - Coordination with other benefits (such as Medicaid, employer or union coverage, and Medigaps)
 - Enrollee satisfaction

There are many ways you can get information on private plans. Friends and family can offer a good perspective on what being a plan member is like. You can also get information directly from Medicare by calling 800-MEDICARE (800-633-4227) or using the “Plan Finder” tool on www.medicare.gov. You should also double check information with the plans directly by calling or checking their websites.

Keep good records and get everything in writing. Do not enroll in a plan unless you have written proof that it will meet your health care needs and cover your preferred doctors, hospitals, and prescription drugs. Whenever you speak to a sales or customer service representative, record their name and the date of your conversation, the information he or she gave you, and the outcome of the call.

5. **Remember: If you are happy with your current coverage, keep it!** You do not have to sign up for a Medicare private health plan, so do not let yourself be pressured into it. Keep in mind that if you choose a Medicare private health plan, the plan you pick can affect the health care you get, and you are limited in when and how often you can switch your plan.



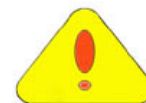
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What to Do if You Have Been a Victim of Marketing Fraud

Marketing fraud can affect the way you receive your health care. If you enroll in a plan based on false information from an insurance broker or the plan itself, or were enrolled without your knowledge, then it is likely that you will not be aware of your plan's coverage rules (such as requirements that you stay within your plan's network of doctors, hospitals and pharmacies, or that you must request prior authorization—permission from your plan—before receiving certain services). If you do not know the rules and so, cannot follow them, in many cases you will end up paying the full cost for services yourself.

If you join a plan unintentionally or based on incorrect or misleading information, or were kept in a plan you did not want (for example, you tried to switch plans but your disenrollment request was not processed) there are a few actions you can take to repair the situation and get out of the plan:

1. **Retroactive disenrollment.** If you have incurred costs from the plan, such as copayments or any cost resulting from a denial of payment, then it is important to get a **retroactive disenrollment**. A retroactive disenrollment would be effective back to the date you joined the plan, and you would have the option to enroll in either a new private health plan (with or without Medicare drug coverage), or Original Medicare and a stand-alone prescription drug plan, as of that date. Your providers will need to resubmit any claims for care you received while enrolled in the plan you left to the new private health plan or to Original Medicare.
2. **Prospective disenrollment.** If you did not incur a lot of costs or were not denied claims as a result of your fraudulent enrollment, it may be better to **prospectively disenroll** from the plan,

which means that you will be disenrolled from the plan at the beginning of the next month, but you will have to pay any costs incurred while you were in the plan. A “special enrollment period” (SEP) will entitle you to change plans outside of the official annual enrollment periods.

Using the SEP, you could switch into another Medicare private health plan that better fits your needs or back to Original Medicare.

How do you get a disenrollment?

To get a prospective or retroactive disenrollment you should call 800-MEDICARE (800-633-4227) and say that you did not mean to enroll in this **type** of insurance plan **and/or** that **particular** plan. You will need to prove a “lack of intent” to enroll. Evidence of “lack of intent” may include:

- An enrollment election signed by you when a legal representative should have signed for you (important for those with a diminished capacity who could be the most susceptible to fraud);
- A request for cancellation of enrollment before the effective date of enrollment in the plan, showing that you realized enrollment in that plan was a mistake;
- Proof that you enrolled in a supplemental insurance plan (Medigap) immediately after enrolling in a private health plan. Such an election may illustrate that you were unaware that you were enrolled in the private health plan at all, or that you did not understand how a private plan works (Technically, insurance companies should not sell you a Medigap if you are in a Medicare private health plan. Having both kinds of coverage is duplicative.); or

- Claims or bills showing you received your first non-emergency or non-urgent services after the effective date of plan coverage **outside** of the plan's network of doctors and hospitals. Such an action may illustrate that you did not know that you were enrolled in the plan at all or did not understand its rules.

Even if you have been paying the premiums for a plan in which you were fraudulently enrolled, that does not necessarily indicate an **informed** decision to enroll. For example, you may have thought you were purchasing a supplemental health insurance policy, as opposed to enrolling in a Medicare private health plan.

It is important to know that it can be a difficult process to obtain a disenrollment from your Medicare private health plan. Often, Medicare hotline representatives do not know how the process works. There are no deadlines for the decisions and no procedures for expediting requests. When granted, the decisions are given by phone rather than in writing. There is no way to appeal an unfavorable decision. Furthermore, it can be difficult to check on the status of your case. Despite these obstacles, you should still attempt either the prospective or retroactive disenrollment.

Are there any other actions you can take?

There are also ways you can **report marketing fraud**. These include

- sending a formal grievance to the plan whose agent committed the fraud;
- reporting the fraud to the Department of Health and Human Services;
 - Phone: 800-HHS-TIPS (800-447-8447);
 - Fax: 800-223-8164;
 - E-mail: HHSTips@oig.hhs.gov;
- reporting the fraud to your elected representatives in Congress by going to www.house.gov; and
- reporting the fraud to your State Department of Insurance, which can be found at http://www.naic.org/state_web_map.htm.

With these tools, you can both report marketing fraud and help to improve the system so that others can avoid the hassle you faced.



Need help choosing a Medicare Part D plan??

Check out the Medicare Rights Center's FREE educational web seminar "Comparing Medicare Prescription Drug Plans: The Medicare Drug Plan Finder" to learn how to search for the Part D plan that best meets your needs.

View a recording of the presentation online:

www.medicarerights.org/webinars.html

Register for our next LIVE webinar, "Changes to Medicare in 2009," to learn about changing Medicare costs and coverage that may affect you in the New Year. This seminar will take place on Thursday, December 11, 2008 at 1pm, Eastern Time.

Register online starting Monday, December 1 at:

www.medicarerights.org/webinars.html

Changes to Medicare in 2009

Whether you get your Medicare benefits through Original Medicare or a Medicare private health plan, you should be aware that your costs will be changing next year. The same goes for your Medicare private drug plan (Part D). Every fall, it is important to review your Medicare coverage to make sure that it will still cover your health care needs at a cost you can afford in the coming year.

If you get your health benefits from Original Medicare—traditional fee-for-service coverage directly from the federal government—your premiums, deductibles and coinsurances generally go up every year. The chart below shows how your costs will change for 2009.

Medicare Part A Costs: 2008 vs. 2009

	2008	2009
Part A Premiums	Free if you have worked for 40 quarters (10 years) or more	Same
	\$233/month if you have worked 30–39 quarters (between 7.5 and 10 years)	\$244/month if you have worked 30–39 quarters (between 7.5 and 10 years)
	\$423/month if you have worked fewer than 30 quarters (7.5 years)	\$443/month if you have worked fewer than 30 quarters (7.5 years)
Hospital Deductible	\$1,024 each benefit period	\$1,068 each benefit period
Hospital Coinsurance	\$0 for days 0–60 each benefit period	Same
	\$256/day for days 61–90 each benefit period	\$267/day for days 61–90 each benefit period
	\$512/day for days 91–150 (non-renewable lifetime reserve days)	\$534/day for days 91–150 (non-renewable lifetime reserve days)
Skilled Nursing Facility Coinsurance	\$0 for days 0–20 each benefit period	Same
	\$128/day for days 21–100 each benefit period	\$133.50/day for days 21–100 each benefit period

See the next page for Medicare Part B Costs: 2008 vs. 2009.

Medicare Part B Costs: 2008 vs. 2009

	2008	2009
Part B Premiums	\$96.40/month for people with income below \$82,000 (\$164,000 for couples who file a joint tax return)	\$96.40/month for people with income below \$85,000 (\$170,000 for couples who file a joint tax return)*
Part B Deductible	\$135 annually	Same

*If your annual income is equal to or greater than \$85,000 (\$170,000 for couples who file a joint tax return), your Part B premium will increase in 2009.

If you have a Medicare private drug plan (Part D), you should check with your plan directly to find out how costs are changing next year. **All** Medicare private drug plans can change the drugs that they cover, the rules for coverage, and costs (such as copayments, coinsurances and deductibles) from year to year. **All plans have their own costs.**

Plans must make their benefits packages at least as good as an actuarial model defined by federal law. This model sets the limit for plan deductibles, approximates when members should enter the coverage gap or “doughnut hole,” and defines the catastrophic coverage limit. Plans base their deductibles and coverage gap thresholds on these numbers but they do not have to use the exact numbers. All plans use the catastrophic coverage limit defined by this model. The chart below shows the deductible limit, coverage gap threshold and catastrophic coverage limit for the 2009 actuarial model. It also shows average Part D premiums for 2009.

Remember, all plans have different costs and those costs may or may not mirror this model. Make sure to check with your particular plan to find out how Part D costs will change for you. Make sure your plan will continue to cover the drugs you take at a cost you can afford and without restrictions. If it will not, you may want to consider changing plans.

See the next page for Medicare Part D Costs: 2008 vs. 2009.

Medicare Part D Costs: 2008 vs. 2009

	2008	2009
Premiums	\$27.93/month national average	\$30.36/month national average (Every plan has a different premium. Check with plans in your area to find out what you will pay.)
Deductible	Up to \$275 annually	Up to \$295 annually (Plans can choose to have a lower annual deductible. Check with plans in your area to find out what you will pay.)
Coverage Gap Threshold	\$2,510	\$2,700 (The amount that you must spend in total drug costs in most plans before you will hit the coverage gap, or “doughnut hole.”)
Catastrophic Coverage Limit	\$4,050	\$4,350 (The amount of money in all plans that you must spend out-of-pocket before your drug costs go down significantly for the rest of the year.)

If you are enrolled in a Medicare private health plan, like an HMO or PPO (sometimes known as “[Medicare Advantage](#)” plans), or a Medicare private drug plan ([Part D](#)), the plan has the right to change which benefits it covers and can change the amount it charges you for your health care (monthly premiums, annual or benefit period deductibles, copayments and coinsurances, catastrophic coverage) from year to year.

You should check directly with your plan to find out how your costs and coverage will be changing for next year. Also check to make sure that the doctors and hospitals you prefer to use will still be in your plan’s network; if they will no longer be network members, in many cases you will have to pay the full cost yourself to go see those providers.

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