A Guide For People With Medicare

Choosing a Medicare Health Plan

Developed jointly by the
Centers for Medicare & Medicaid Services
and the
Agency for Healthcare Research and Quality

Centers for Medicare & Medicaid Services

This booklet, ***Choosing a Medicare Health Plan***, is one of a series of booklets for people with Medicare. Other titles include ***Choosing a Doctor, Choosing Treatments, Choosing a Hospital***, and ***Choosing Long-Term Care***. Each booklet can help you to make health care choices. Use this booklet to help you decide how to get your Medicare health care.

To get copies of this booklet in Braille or Spanish, call 1-800-633-4227. TTY users should call 1-877-486-2048.

CONTENTS

This Guide has a lot of tips and questions to help you make the health plan choice that is right for you. Get as much information as you can so you can make your best choice. But it is not necessary, or even possible, for every person to do everything this Guide suggests. Do as much or as little as you feel comfortable with.

A note about the symbols used in this booklet:

 means a mailing address

 means a telephone number

 means a number for TTY text telephones for people with special equipment

 means a computer web site address

If you don't have a computer, your local library or senior center may be able to help you find information on their computers.

How This Booklet Can Help You

You may be new to Medicare and unaware of your choices. Or you may be thinking about changing how you get your Medicare health care. This booklet can help you choose a Medicare health plan that meets your needs.

Choosing a Medicare health plan is a very important decision. It determines how you get your health care. Your health plan choice affects the following:

- **Cost**—how much you will pay.
- **Doctor choice**—who will care for you (doctors and other health care providers), and how much choice you will have.
- **Benefits**—what kind of care you will get (which services are covered), and if you get extra benefits, like prescription drugs, eye exams, hearing aids, or routine physicals.
- **Convenience—**where you will get your care (which hospitals, for example), and any rules you need to follow.
- **Quality**—how you will be cared for (the quality of care you get).

This booklet is divided into two sections. The basics you need to know are in the first section. The second section, which starts on page 25, has more details if you want them.

A Few Words About Medicare

Medicare offers you different ways to get your Medicare benefits. These different options are called Medicare health plans. Some private companies contract with the Medicare program to offer Medicare health plans. How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

Medicare offers the following types of Medicare health plans:

Original Medicare Plan (sometimes called fee-for-service)

Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. In the Original Medicare Plan you may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service. You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment). Some services aren't covered, like most prescription drugs.

You are in the Original Medicare Plan if you use your red, white, and blue Medicare card when you get your health care.

Some people with the Original Medicare Plan (Part A and Part B) buy a Medigap (Medicare Supplement Insurance) policy from a private company to help pay health care costs that this plan doesn't cover. (See page 32 for more about Medigap policies.)

Medicare + Choice Plans (pronounced "Medicare Plus Choice")

You can get your coverage through the Original Medicare Plan or Medicare + Choice Plans. Congress created the Medicare + Choice program to provide you with more choices and, sometimes, extra benefits, by letting private companies offer you your Medicare benefits. Your choices may include the following:

- Medicare Managed Care Plans,
- Medicare Private Fee-for-Service Plans, and
- Medicare Preferred Provider Organization Plans.

Medicare + Choice Plans must cover at least the same benefits covered by Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, like coverage for prescription drugs or additional days in the hospital.

These plans are available in many areas of the country. For information about the Medicare health plans available in your area, look at www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227).

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice Plan manages the Medicare coverage for its members. If Medicare + Choice Plans are available in your area, you can join one and get your Medicare-covered benefits through the plan. You must have both Medicare Part A and Part B to join a Medicare + Choice Plan. However, if you are in a Medicare Managed Care Plan and have only Part B, you may stay in your plan. By joining one of these Medicare + Choice Plans, you can often get extra benefits, like coverage for prescription drugs or additional days in the hospital. You may have to pay a monthly premium for the extra benefits. The plan may also have special rules that you need to follow.

It is important to know how you get your Medicare health care. To learn more about Medicare, look at your copy of the *Medicare & You* handbook (CMS Pub. No. 10050) that is mailed each fall to people with Medicare. You can order one from the Medicare web site or by calling 1-800-MEDICARE (1-800-633-4227).


www.medicare.gov


1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)


1-877-486-2048 (toll-free)

Other information about Medicare and how to choose a Medicare health plan is also on the Medicare web site. If you don't have a computer, your local library or senior center may be able to help you.

NOTES

Section 1

The Basics

Words You Should Know

Coinsurance is the percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B (see page 9). In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20 percent).

Copayment is (in some Medicare health plans) the amount you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible (Medicare) is the amount you must pay for health care, before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

Premium is the periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Primary care doctor is a doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Managed Care Plans, you must see your primary care doctor before you see any other health care provider.

Referral is an written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.

Respite care is temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take time off.

Service area is the area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

Steps to Choosing a Medicare Health Plan

The six steps below can help you find a Medicare health plan that will meet your needs and give you good quality care.

Step 1. Learn about Medicare and the types of Medicare health plans.

Step 2. Find out which Medicare health plans are available in your area.

Step 3. Call the plans you are most interested in and ask questions.

Step 4. Find out how the plans rate in quality of care.

Step 5. Visit or call the doctors' offices where you would get your care.

Step 6. Review your plan choices every year in the fall.

Read on for more about each of these steps.

Step 1. Learn about Medicare and the types of Medicare health plans.

Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care, but you must meet certain conditions. Most people don't have to pay a monthly payment, called a premium, for Part A because they or a spouse paid Medicare taxes while they were working.

Medicare Part B (Medical Insurance) helps cover your doctors' services, and outpatient hospital care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. It starts to pay after you have paid the Part B deductible ($100 in 2003). Part B also helps pay for some covered services and supplies when they are medically necessary. Part B also covers some preventive services such as diabetes monitoring, screening mammograms, and flu shots. Part B is voluntary. If you choose to have Part B, you must pay a monthly premium ($58.70 in 2003).

Some things are the same whether you get your Medicare health care coverage from the Original Medicare Plan or a Medicare + Choice Plan:

- You are in the Medicare program.
- You get at least all the Medicare Part A covered services.
- You get all the Medicare Part B covered services if you pay the monthly Part B premium ($58.70 in 2003). You must have Part A and Part B to join a Medicare + Choice Plan. If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan.
- The Medicare program can provide you information about the quality of the care given by Medicare health plans.
- The Medicare program pays for part of your health care.

Other things—like cost, choice of doctor, benefits, convenience, and quality—are different, depending on who provides your health care and whether you have the Original Medicare Plan or a Medicare + Choice Plan.

It is important to think about cost, choice of doctor, benefits, convenience, and quality when choosing how to get your Medicare health care. Below is more information about these types of Medicare health plans. You can also find more information about Medicare health plans in the *Medicare & You* handbook.

Original Medicare Plan (sometimes called fee-for-service)

The Original Medicare Plan is a "fee-for-service" plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice Plan.

In the Original Medicare Plan, you may go to any doctor, specialist, hospital, or other facility that accepts Medicare. Generally, a fee is charged each time you get a health care service. You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).

The Original Medicare Plan doesn't pay for or cover everything. To get extra coverage, you may also buy a Medigap policy. This type of policy only works with the Original Medicare Plan. For more information on Medigap policies, see page 32. You may also have or qualify for employer or union health coverage, help from your State, TRICARE for Life (for military retirees and their spouses and survivors), veterans' benefits, Programs of All-inclusive Care for the Elderly (PACE), or other insurance, like long-term care insurance. For more information on these other types of coverage, see page 33.

Medicare + Choice Plans (pronounced "Medicare Plus Choice")

Medicare + Choice Plans currently include Medicare Managed Care Plans, Medicare Private Fee-for-Service Plans, and Medicare Preferred Provider Organization Plans. Remember, you must have Medicare Part A and Medicare Part B to join a Medicare + Choice Plan. If you are already in a Medicare Managed Care Plan and have only Part B, you may stay in your plan. You must continue to pay the Medicare Part B premium ($58.70 per month in 2003) and any additional premium the plan may charge.

- **Medicare Managed Care Plans.** In most of these plans, there are doctors and hospitals that join the plan (called the plan's "network"). You may need to get most of your care and services from the plan's network. Call the plan to see which doctors and hospitals are in the plan.

  When you join a plan, you may be asked to choose a primary care doctor. If you want to change your primary care doctor, you can ask your plan for the names of other plan doctors in your service area. The service area is where the plan accepts members and where plan services are provided. If you get health care outside the service area of the plan, you may pay more.

  Some Medicare Managed Care Plans offer a Point-of-Service option. This allows you to go to other doctors and hospitals who aren't part of the plan ("out-of-network"), but it may cost extra.

  In a Medicare Managed Care Plan, you usually need a referral to see a specialist (like a cardiologist). A referral is an OK from your primary care doctor for you to see a specialist or get certain services.

  Some special rules might apply in emergencies or for urgently needed care. Also, there are special rules for certain services. For example, if you are a women, you can go once a year, without a referral, to a specialist in the network for Medicare-covered routine and preventive women's care services. If the specialist you need isn't available, the plan will arrange for care outside the network.

  Doctors can join or leave Medicare Managed Care Plans at any time. If your primary care doctor should leave your plan, your plan will notify you in advance and give you a chance to pick a new doctor.

  At the end of each year, Medicare Managed Care Plans may leave the Medicare program or change their benefits. However, new plans may also become available.

- **Medicare Private Fee-for-Service Plans.** The Medicare Private Fee-for-Service Plan pays the doctor or hospital for the care you get. You may have to pay a premium and other costs (like a copayment or coinsurance) that are different than under the Original Medicare Plan. You can go to any Medicare-approved doctor or hospital that is willing to give you care and accepts the terms of your plan's payment. You should check how much your out-of-pocket costs will be before joining a Medicare Private Fee-for-Service Plan.

The private company provides health care coverage to people with Medicare who join this plan. Before you get care, tell the doctor or hospital that you have a Medicare Private Fee-for-Service Plan. If the doctor or hospital agrees to treat you, you may also have to pay other costs (like a copayment or coinsurance) for the services you get. The private company, rather than the Medicare program, decides how much it will pay and what you pay for the services you get.

You may get extra benefits not covered under the Original Medicare Plan, like prescription drugs or extra days in the hospital.

At the end of each year, the companies offering Medicare Private Fee-for-Service Plans can decide to join, stay with, or leave Medicare.

- **Medicare Preferred Provider Organization Plan**. These plans work with many of the same rules as Medicare Managed Care Plans. However, in this plan you don't need referrals to see a specialist provider. You may have to get plan approval before you get certain services.

  In most cases, you can see any doctor or provider that accepts Medicare. However, if you go to doctors, hospitals, or other providers who aren't part of the plan ("out-of-network" or "non-preferred"), it may cost extra.

  Every plan is different in terms of what is covered out-of-network and how much you will have to pay. Call the plan you are interested in to find out.

For more information about a Medicare + Choice Plan, call the plan.

Choosing the right health coverage is an important—but sometimes difficult—decision. The "Medicare Personal Plan Finder" helps you narrow down your Medicare health plan choices and choose the plan that is best for you. You can also get information about special programs that might help you pay health care costs that Medicare doesn't cover. When you use the "Medicare Personal Plan Finder," you will get a personalized summary page with general information to help you compare plans in your area. You can also get detailed information about any plan available in your area.

You can get this personalized information two ways:

Look at www.medicare.gov on the web for fast results. Select "Medicare Personal Plan Finder."

Call 1-800-MEDICARE (1-800-633-4227). For English, press "1" or for Spanish, press "2." Select option "0." A Customer Service Representative will help you. You will get your results in the mail within three weeks.

To get this information, you will need to answer some simple questions:

- What parts of Medicare do you have (Part A and/or Part B)?
- What is your age?
- What is your ZIP code?

If you want information about programs that may help with your health care costs, you will need to answer additional questions about your income and resources. Any information you give is always kept private.

If you want to talk to someone about your health plan choice, call your State Health Insurance Assistance Program (SHIP). Call 1-800-MEDICARE (1-800-633-4227) for the SHIP telephone number in your state. You can also find some SHIP web addresses and telephone numbers on the Medicare web site.

www.medicare.gov
(Select "Helpful Contacts.")

Special Rules for People with End-Stage Renal Disease

If you have End-Stage Renal Disease (ESRD), you usually can't join a Medicare + Choice Plan. However, if you are already in a plan, you can stay in the plan or join another plan offered by the same company, in the same state. If you have had a successful kidney transplant, you may be able to join a plan. If you have ESRD and are in a Medicare + Choice Plan that leaves Medicare or no longer provides coverage in your area, you have a one-time right to join a new Medicare + Choice Plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare + Choice Plan at a later date as long as you are in a managed care election period. Call 1-800-MEDICARE (1-800-633-4227) for more information about ESRD and Medicare health plans.

Step 2. Find out which Medicare health plans are available in your area.

In some areas, only the Original Medicare Plan is available. But in other areas, there are other Medicare health plan choices. Here are two ways to learn what plans are available in your area:

- Look on the Medicare web site. If you don't have a computer, your local library or senior center may be able to help you find this information on their computers. The "Medicare Personal Plan Finder" helps you narrow down your Medicare health plan choices and choose the plan that is best for you.

   www.medicare.gov
  (Select "Medicare Personal Plan Finder.")

- Call 1-800-MEDICARE; then select option "0."

   1-800-MEDICARE (1-800-633-4227)
  (24 hours a day, 7 days a week)

   1-877-486-2048 (toll-free)

Step 3. Call the plans you are most interested in and ask questions.

Medicare health plans differ in cost, choice of doctors and hospitals, and extra benefits like prescription drugs. Check to make sure the plan offers the service you need, their doctors and hospitals are easy to get to, and their offices are open when you need them. It is important to find out as much as you can about where you will get your health care before you choose a health plan.

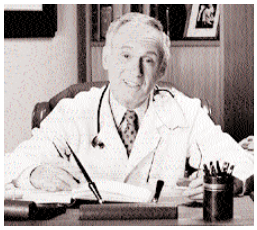
Make a list of Medicare health plans in your area that you are interested in joining. Then call the plans and ask questions. You can also ask them to send you more information about the plan, called a Summary of Benefits. Compare the information you get to see which plan best meets your needs.

On the next few pages, there are some questions you may want to ask when you call. If you think of others, write them in the space at the bottom of page 18.

Questions To Ask When You Call Health Plans

	Plan 1	Plan 2	Plan 3
ABOUT COSTS, DOCTOR CHOICE, AND CONVENIENCE			
Will I pay an extra premium in addition to my Part B premium? If so, how much? How often?			
Will I have a copayment for doctor visits? If so, how much?			
Does the plan pay a maximum amount for certain services? If so, which services? How much?			
Will I pay a deductible or copayment for services in the hospital? home health care? skilled nursing care?			
How soon can I see a doctor? Do I need to notify the plan first or get a referral to see a specialist?			
Are doctors' offices located close to me?			
Are doctors' offices open at night and on weekends?			

	Plan 1	Plan 2	Plan 3
Is there a telephone "hotline" for medical advice?			
Where would I get lab work done?			
If the plan is a Medicare Managed Care Plan, also ask: What doctors and hospitals are in the plan? (Check to see if your doctor is in the plan if you want to keep seeing him or her.)			
Can I see the doctor I want? If so, is he/she accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
How can I see a specialist?			
Can I choose which specialist I want to see?			
What if the plan doesn't have the type of specialist I need?			
Will I pay more if I use doctors or hospitals outside the plan? If so, how much?			



	Plan 1	Plan 2	Plan 3
If the plan is a Medicare Private Fee-for-Service Plan, also ask: Does the doctor I want to see know and accept the terms of the plan's payment?			
Do I have to pay a premium and other costs (like a copayment or coinsurance)?			
ABOUT EXTRA BENEFITS LIKE PRESCRIPTION DRUGS Does the plan cover routine physical exams?			
eye exams and eyeglasses?			
hearing exams and hearing aids?			
dental exams and dental treatments?			
respite care, adult day care, or caregiver services?			
wellness programs like nutrition counseling and help to stop smoking?			

(continued on page 18)

	Plan 1	Plan 2	Plan 3
programs that help members with specific chronic health problems, like asthma, diabetes, or heart conditions? other benefits?			
Does the plan cover prescription drugs? If so, does the plan only pay for some prescription drugs and not others? If so, how do I find out if mine are covered?			
May I use my regular pharmacy?			
Are mail-order prescriptions available?			
Is there a maximum dollar limit on what the plan will pay for my prescription drugs each year? If so, how much?			
Will I pay more if I use a brand-name drug instead of a generic drug?			

Other questions:

Step 4. Find out how the plans rate in quality of care.

Quality health care means doing the right thing, at the right time, in the right way, for the right person—and having the best possible results. To help patients get the best quality of care, Medicare has certain standards for Medicare health plans and providers.

- All Medicare doctors must be licensed in the states where they practice.
- The Medicare program certifies hospitals, nursing homes, and suppliers.
- Medicare + Choice Plans must meet State and Federal Government standards.
- Medicare Managed Care Plans must have a program to assure quality of care before they can get a Medicare contract.

Beyond these basic standards, the quality of care in plans may vary. To check up on quality, Medicare gets information each year from people with Medicare about how satisfied they are with their plans. Medicare also collects information every year on the services the plans give their members (like flu shots and diabetes monitoring). You can use quality information to help you make your health plan choice.

The Medicare web site gives information for more than ten different quality measures of how well a plan keeps its members healthy and treats them when they are sick and how satisfied members are with the care they get. You can find out the percentage of people who chose to leave their Medicare Managed Care Plan during the year and the reasons they left. You can also get this information by calling 1-800-MEDICARE (1-800-633-4227).

www.medicare.gov
(Select “Medicare Health Plan Compare.”)

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Here are some other ways you can see how the Medicare health plans in your area rate in quality:

- Ask your family members, friends, and other people you know who are in Medicare health plans if they are satisfied with the care they get.
- Call your local office of consumer affairs and ask if they have information on the quality of Medicare health plans in your area.
- Call your State Insurance Department or your State Health Department. Ask if you can get information on the quality of Medicare health plans in your area.

For more information about plan quality, see Section 2.

Step 5. Visit or call the doctors' offices where you would get your care.

Before you make a final decision about which Medicare health plan to choose, you may want to visit or call the doctors' offices where you would go to get your health care if you joined this plan. You may want to make an appointment to talk to someone before you visit.

Some Medicare Managed Care Plans have their own health centers or office buildings where doctors, labs, and other services are located in a single place. Ask if you can see these when you visit. Other plans may refer you to an independent lab or another office for other services.

Here are some tips to help you get ready for your visit:

- Talk to your doctor about your health plan choice.
- Go over any information you have already gotten about the plan.

ny questions you may have about the doctor's office. nost important ones first. This will help to make sure ou ask these questions when you visit or call.

After your visit or call, ask yourself the following questions:

- Did the staff treat patients with respect? Yes ___ No ___
- Did I feel comfortable? Yes ___ No ___
- Was the office clean? Yes ___ No ___
- Are the hours and location convenient? Yes ___ No ___

Step 6. Review your plan choices every year in the fall.

Medicare health plans can join or leave Medicare each year. They can also change their costs and extra benefits. Fall is a good time to think about health coverage for the coming year. Check to see that your plan still covers your health care and financial needs. If not, you can look into other ways to get your health care. Repeat the steps to choosing a Medicare health plan to be sure you are in the best plan for you.

Joining a Medicare Health Plan

If you are in the Original Medicare Plan and want to stay in it, you don't have to do anything.

If you want to join a Medicare + Choice Plan, consider the following:

- You can call the plan and ask for an enrollment form. Fill out the form and mail it to the plan.
- You can get an enrollment form from a plan representative. Fill out the form and mail it to the plan, or give it to the plan representative. The plan representative can help you fill out the form.
- You will get a letter from the plan telling you when your coverage begins.

Generally, you can join a Medicare + Choice Plan at any time. However, Medicare + Choice Plans must accept new members from November 15 through December 31 of each year. If you join a Medicare + Choice Plan during this time, your coverage begins on January 1 of the next year. If you join a Medicare + Choice Plan at any time, generally, your coverage will begin the first day of the month after the plan gets your enrollment form.

Note: Some Medicare + Choice Plans limit the number of members in their plans. These plans can't accept new members when they reach their limit. A plan can tell you if it is signing up new members. Also, if you are in an institution (like a nursing home), check with the plan to see if you may be able to join at other times.

Things To Remember

- **No matter what Medicare health plan you choose, you are still in the Medicare program.**
- **If you are in a Medicare + Choice Plan, you must continue to pay the monthly Part B premium ($58.70 in 2003).**
- **All Medicare + Choice Plans agree to stay in the Medicare program for a full year at a time. Each year the plans decide whether to stay in the Medicare program for another year.**
- **If you leave a Medicare health plan, you won't lose health coverage. You can choose another Medicare + Choice Plan if one is available, or you can get care from the Original Medicare Plan. (See "Switching Medicare Health Plans" on page 23.)**
- **You must pay any additional premium the Medicare + Choice Plan charges to remain in the plan.**
- **In most Medicare Managed Care Plans, you are likely to need to get most of your care and services from the plan's network.**
- **In a Medicare Private Fee-for-Service Plan, you can go to any doctor or hospital that accepts the payment terms of the plan.**
- **In a Medicare Preferred Provider Organization, you don't need referrals to see a specialist provider.**

Switching Medicare Health Plans

You may leave (disenroll from) a Medicare + Choice Plan at any time for any reason as long as the plan is accepting new members.

You can leave your Medicare + Choice Plan to join a new Medicare + Choice Plan by enrolling in the new plan. You don't need to tell your old plan or send them anything. You will be disenrolled automatically from your old plan when your new plan coverage begins. You should get a letter from your new plan telling you when your coverage starts.

If you want to leave your Medicare + Choice Plan and return to the Original Medicare Plan, do so in one of three ways:

1. Write or call your plan,

2. Visit, call, or write the Social Security Administration, or

3. Call 1-800-MEDICARE (1-800-633-4227).

Tell them you want to leave your Medicare + Choice Plan. The plan should send you a letter with the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

Note: If you want to change to the Original Medicare Plan and buy a Medigap policy, you need to leave your Medicare + Choice Plan in one of the three ways listed above. Simply signing up for the Medigap plan **won't** end your Medicare + Choice Plan coverage.

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have these rights whether you are in the Original Medicare Plan or a Medicare + Choice Plan. They include the right to certain information, emergency care, appeals, treatment choices, and privacy. If you are in a Medicare + Choice Plan you have additional rights, like the right to culturally competent services and the right to file a grievance.

You can find more information on your patient rights by reading *Your Medicare Rights and Protections* (CMS Pub. No. 10112). To order a free copy, visit the Medicare web site or call 1-800-MEDICARE (1-800-633-4227).


www.medicare.gov
(Select "Publications.")


1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)


1-877-486-2048 (toll-free)

Section 2

If You Want To Know More

This section has more detailed information on choosing a Medicare health plan, including the following:

- Quality Information From Medicare and Other Groups
- Medigap Policies
- Other Types of Coverage
- Where To Get More Information

More Words You Should Know

Accredited (accreditation) means having a seal of approval. Being accredited means that a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care of health care facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/URAC.

Medigap policy is a Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Performance measure is information that shows how well a health plan provides a certain treatment, test, or other health care service to its members. For example, Medicare uses performance measures from NCQA's Health Plan Employer Data and Information Set (HEDIS®) to get information on how well health plans perform in quality, how easy it is to get care, and members' satisfaction with the health plan and its doctors.

Report card is a way to check up on the quality of care delivered by health plans. Report cards provide information on how well a health plan treats its members, keeps them healthy, and gives access to needed care. Report cards can be published by States, private health organizations, consumer groups, or health plans.

Quality Information Reported by Medicare

Medicare collects quality and satisfaction information from Medicare health plans and people with Medicare and reports this back to you. This information can be used to help you choose a health plan. An explanation of the information and where to get it follows.

Surveys of Members' Experiences and Satisfaction With Health Plans

Every year the Medicare program does a survey of people in Medicare health plans (including the Original Medicare Plan) to find out how satisfied they are with their plans. This survey is called the Medicare Consumer Assessment of Health Plans Survey (CAHPS®). The survey asks how people with Medicare rate their health plans and the health care they got in the last six months. The survey asks questions like "Did your doctor explain things in a way you could understand?" and "Was it easy to get a referral to a specialist?"

CAHPS® was designed by national experts in health care quality, under a project funded by the Agency for Healthcare Research and Quality.

How Well Health Plans Meet Quality Standard of Care

Health plans send Medicare quality information on the health care they give using the Health Plan Employer Data and Information Set (HEDIS®). This is a special way to gather quality information, often called "performance measures." Medicare carefully checks this information for accuracy.

HEDIS® has information like the percent of women who get a mammogram (breast x-ray) and whether health care providers stay in the plan. You may find that two health plans have the same benefits at the same cost, but one may have higher ratings on some quality information than the other.

HEDIS® is sponsored by the National Committee for Quality Assurance, which is a private, not-for-profit organization.

Reasons Members Leave and Stay With Health Plans

Medicare gets information from Medicare Managed Care Plans and can tell the percentage of plan members who chose to leave their health plan. The information doesn't include members who died, moved out of the area, weren't eligible for managed care under Medicare, were no longer offered the plan through their former employer, or whose plan decided not to serve people with Medicare in that area.

Medicare reports information from the Medicare Consumer Assessment of Health Plans Disenrollment Survey. The survey tells why people chose to leave their Medicare Managed Care Plan by asking questions like "Did you have problems getting the care you needed?" or "Have you had problems with the plan doctors or other health care providers?"

Results of Staying in a Health Plan

The Health Outcomes Survey (HOS) tells how well Medicare health plans do, over time, in taking care of their members. The HOS uses information reported by Medicare plan members to measure how people feel (emotional health) and what they are able to do (physical health). By comparing whether plan members felt better, stayed the same, or felt worse physically and emotionally, the HOS tells us how well these health plans are caring for their patients.

You can get Medicare quality information by using the Medicare web site or calling 1-800-MEDICARE (1-800-633-4227).


www.medicare.gov
(Select "Medicare Personal Plan Finder.")


1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)


1-877-486-2048 (toll-free)

Other Sources of Health Plan Quality Information

There are many other sources of information on the quality of care given by health plans. You can use this information to help in choosing a Medicare health plan. Some of these sources are listed below. If you don't have a computer, your local library or senior center may be able to help you find the information on their computers.

NCQA's Health Plan Report Card

The National Committee for Quality Assurance (NCQA) evaluates and rates managed care plans, including Medicare Managed Care Plans. NCQA sets the standards for the quality of care that health plans give their members. Accreditation of a health plan by the NCQA is a nationally recognized seal of approval.

NCQA's "Health Plan Report Card" provides quality information on various performance measures that show how well a health plan performs according to NCQA standards. Using the database on NCQA's web site, you can create a report card that gives results on how well a plan keeps its members healthy or treats them when they are sick.


www.NCQA.org
(Select "Health Plan Report Card.")

Quality Check™

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits over 20,000 health care organizations, hospitals, programs, and plans. JCAHO standards focus on areas that are most likely to improve patients' health, like preventive services to keep you healthy and making it easy to get care.

The JCAHO web site includes "Quality Check™." You can find out if the health plan you are considering is accredited by JCAHO by using Quality Check™. Quality Check™ also has reports with information on the organization's overall performance and how it compares to others in specific areas.

✉ Joint Commission on Accreditation of
Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

 www.jcaho.org

 1-630-792-5800

American Accreditation HealthCare Commission/URAC

The American Accreditation HealthCare Commission/URAC develops accreditation standards and programs for Medicare Managed Care Plans as well as for other managed care organizations. You can get an alphabetical list of these organizations on the Commission's web site. Or you can ask for a copy to be mailed to you.

✉ American Accreditation HealthCare Commission/URAC
1275 K Street NW, #1100
Washington, DC 20005

 www.urac.org

 1-202-216-9010

State Quality Reports

Some States publish reports on how well health plans in the State give care to their members and how satisfied people are with the care they get. Below are three examples. Call your local library and ask whether your State publishes any reports on the quality of care of health plans available in your area.

- **Maryland**
  The Maryland Health Care Commission publishes reports on how well managed care plans in Maryland provide services to keep their members healthy and how easy it is to get care when they are sick.

   www.mhcc.state.md.us
  (Select "HMO Guides.")

- **New Jersey**
  The New Jersey Department of Health and Senior Services publishes report cards for HMOs and point-of-service plans in New Jersey. You can read these reports on the web site. You can also compare the performance of specific plans.

   www.state.nj.us/health
  (Select "Consumer Report Cards" from the "health statistics - reports" pull down menu. Then select "NJ HMOs Performance Reports.")

- **Pennsylvania**
  The Pennsylvania Health Care Cost Containment Council (PHC4) publishes reports on the quality of Pennsylvania HMOs. One of these reports is on the role of HMOs, including Medicare HMOs, in managing diabetes.

   www.phc4.org
  (Select "Health Plans.")

Medigap (Medicare Supplement Insurance) Policies

Medigap (Medicare Supplement Insurance) policies are sold by private insurance companies. This type of policy is called "Medigap" because it covers some of the gaps in Original Medicare Plan coverage. These gaps include the following:

- Medicare coinsurance and copayment amounts
- Medicare deductibles
- Items and services not covered by Medicare

Premiums for Medigap policies vary by state and by insurer. Premiums may be different depending on your age and the way companies price their policies. You pay a monthly premium for the policy in addition to the monthly Medicare Part B premium ($58.70 in 2003).

With most Medigap policies, you can go to any doctor or hospital that accepts Medicare. In the type of Medigap policy called "Medicare SELECT," you must use the plan's hospitals, and in some cases the plan's doctors, to get full Medigap benefits.

For more information on Medigap policies, look in the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). You can order a free copy from the Medicare web site or by calling 1-800-MEDICARE (1-800-633-4227). You can also select "Medicare Personal Plan Finder" on the Medicare web site to compare the Medigap policies available in your area.


www.medicare.gov


1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)


1-877-486-2048 (toll-free)

Your State Health Insurance Assistance Program also has information on Medigap policies. The telephone number for your State is listed in the *Medicare & You* handbook.

Finding Out About Other Types of Coverage

You may be able to get other types of health care coverage besides Medicare:

- You may be able to get health care coverage from your employer or union if you (or your spouse) are still working. Even if you are retired, you may be able to get health care coverage based on your previous employment. Check with your employer or union to see if you qualify. Talk to your benefits administrator before you make any health plan decisions.

- If you have limited income and assets, you may qualify for help from your State to pay some health care costs. Call your State Medical Assistance Office for more information on these programs. You can get the telephone number on the Medicare web site or by calling 1-800-MEDICARE (1-800-633-4227).

   www.medicare.gov
  (Select "Helpful Contacts.")

   1-800-MEDICARE (1-800-633-4227)
  (24 hours a day, 7 days a week)

   1-877-486-2048 (toll-free)

- If you are a veteran, call the U.S. Department of Veterans Affairs (VA) for information about benefits and services available in your area. You can also visit the VA web site for more information.

   1-877-222-VETS (1-877-222-8387)

   www.va.gov
  (Select "Health Benefits & Services.")

- If you or your spouse are retired from military service, you may be eligible to get health care benefits through TRICARE for Life. Call TRICARE for Life or visit their web site.

   1-888-DOD-LIFE (1-888-363-5433)

   www.tricare.osd.mil

- You may be eligible to get health care benefits from the PACE program (Programs of All-inclusive Care for the Elderly). PACE combines medical, social, and long-term care services for frail people. PACE is available only in States that have chosen to offer it under Medicaid.

  To find out if you are eligible, to find a PACE site near you, or for more information, call your State Medical Assistance Office. Call 1-800-MEDICARE (1-800-633-4227) for the State Medical Assistance Office telephone number in your state. You can also get information from the Medicare web site.

   www.medicare.gov/Nursing/Alternatives/PACE.asp

- You may be able to get health care coverage from a long-term care insurance policy. Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare doesn't pay for long-term care.

  For more information about the types of long-term, get a free copy of *Choosing Long-Term Care: A Guide for People with Medicare* (CMS Pub. No. 02223).

   www.medicare.gov
  (Select "Publications.")

   1-800-MEDICARE (1-800-633-4227)
  (24 hours a day, 7 days a week)

   1-877-486-2048 (toll-free)

For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department or the National Association of Insurance Commissioners. Call 1-800-MEDICARE (1-800-633-4227) for the State Insurance Department telephone number in your state. You can also contact the National Association of Insurance Commissioners for a copy.

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2604

www.naic.org
Select "Consumers" and then select "Consumer Publications."

1-816-783-8300

Getting More Information

More information is available to help you make your health plan choice. You can order free booklets, and some information is on the web. If you don't have a computer, your local library or senior center may be able to help you find the information on their computers.

Medicare Information

Many booklets can be ordered from the Medicare web site and by calling 1-800-MEDICARE (1-800-633-4227). These free booklets explain Medicare benefits, coverage, rights, health plan choices, and more. A few examples are listed below.

- *Your Guide to Private Fee-for-Service Plans* (CMS Pub. No. 10144)
- *Medicare Savings Programs* (CMS Pub. No. 10126)
- *Your Medicare Rights and Protections* (CMS Pub. No. 10112)
- *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110)

 www.medicare.gov
(Select "Publications.")

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

The Medicare web site lets you get detailed information on Medicare health plans, Medigap policies, nursing homes, and dialysis facilities by State or ZIP Code. You can use the "Medicare Personal Plan Finder" to help you locate and compare health plans in your area. You can also find information on programs that offer help in buying prescription drugs and a list of doctors and suppliers in your area who accept Medicare.

 www.medicare.gov
(Select "Medicare Personal Plan Finder" and "Medicare Health Plan Finder" for health plans and Medigap plans, "Nursing Home Compare" for nursing homes, "Dialysis Facility Compare" for dialysis facilities, "Prescription Drug Assistance Programs" for drug assistance programs for individuals in need, "Participating Physician Directory" for Medicare participating physicians, "Supplier Directory" for Medicare participating suppliers, and "Your Medicare Coverage" for health care coverage in the Original Medicare Plan.)

AHRQ Publications Clearinghouse

This service of the Agency for Healthcare Research and Quality (AHRQ), part of the Federal Government, offers these free brochures to help you choose a health plan.

- *Your Guide to Choosing Quality Health Care* (47 pages) (AHCPR 99-0012)

- *Choosing and Using a Health Plan* (29 pages) (AHCPR 97-0011)

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547

www.ahrq.gov
(Select "Health Plans.")

1-800-358-9295

AARP Consumer Resources

The American Association of Retired Persons (AARP) has many free brochures on health insurance and how to choose and use a Medicare health plan. Some are listed below. The AARP web site lists other resources. Order brochures by publication number.

- *Checkpoints for Managed Care: How to Choose a Health Plan* (D16342)
- *Making Medicare Choices* (D16747)
- *Selecting Medicare Supplemental Insurance* (D16813)
- *9 Ways to Get the Most From Your Managed Health Care Plan* (D16615)

American Association of Retired Persons
610 E. Street NW
Washington, DC 20049

www.aarp.org
(Select "Health and Wellness.")

1-800-424-3410

Guide to Health Insurance

This free booklet from the Health Insurance Association of America summarizes different kinds of health insurance plans and answers frequently asked questions about health plan coverage.


Health Insurance Association of America
1201 F Street NW, Suite 500
Washington, DC 20004-1204


www.hiaa.org
(Select "Consumer Information.")


1-202-824-1600

Putting Patients First

This guide from the National Health Council lists where you can get information for 170 conditions and diseases and includes a short consumer's checklist for evaluating health plans.


National Health Council
1730 M Street NW, Suite 500
Washington, DC 20036


www.nationalhealthcouncil.org
(Select "Publications.")


1-202-785-3910

Healthfinder

The Healthfinder web site, run by the U.S. Department of Health and Human Services, offers reliable consumer information from the Federal Government and its many partners. It has links to web sites with consumer health information, on-line publication catalogs, and on-line brochures.


www.healthfinder.gov

How to Choose a Health Plan

The American Association of Health Plans (AAHP) web site gives tips for consumers on gathering information for choosing a managed care health plan.

www.aahp.org
(Select "inside aahp" and then select "For Consumers." Then select "How to Choose a Health Plan.")

Health Pages

Health Pages is a commercial web site with articles for consumers on many health care topics, including how to choose a health plan.

- *Your Complete Guide to Managed Care* (15 pages)
- *Medicare and the Managed Care Option* (7 pages)
- *Medicare: Bridging the Gaps* (15 pages)

You can read or print these articles from your computer. You can also review and compare managed care plans, including Medicare Managed Care Plans, on-line by state and county.

www.thehealthpages.com

HealthScope

The HealthScope web site, from the Pacific Business Group on Health, offers information on using quality report cards and other information to choose a health plan. It includes ratings of HMOs in California.

www.healthscope.org
(Select "Health Plans.")

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use $300

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Agency for Healthcare Research and Quality

This booklet, ***Choosing a Medicare Health Plan***, is one of a series of booklets for people who have Medicare. Other titles include ***Choosing a Doctor, Choosing Treatments, Choosing a Hospital,*** and ***Choosing Long-Term Care***. Each booklet can help you to make health care choices. Use this booklet to help you decide how to get your Medicare health care.

To get copies of this booklet in Braille or Spanish, call 1-800-633-4227. TTY users should call 1-877-486-2048.