Non-Renewal Questions and Answers

The Health Care Financing Administration (HCFA) is the Federal governmental entity that administers the Medicare program. This includes administration of Medicare risk-based contracts with health maintenance organizations (HMOs). Some of these plans have decided not to renew their contracts with HCFA to provide services to Medicare beneficiaries in certain States and selected counties.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan non-renewals and service area reductions.

Q1 HMO plans are leaving Medicare. How do beneficiaries get information about whether this is true?

A1 Individuals affected by a termination should have received notification from the HMO no later than November 2, 1998. Information regarding terminations is also posted on the HCFA website at *<www.hcfa.gov>*.

Q2 Why are HMOs terminating their contracts with HCFA?

A2 HMOs are independent businesses that make business decisions to either participate or not participate in a contract with HCFA. HMOs voluntarily choose to enter into contracts with HCFA to serve Medicare enrollees. Each year, HMOs have to make a choice to continue their contracts or to adjust premiums and/or benefits. Some HMOs have made business decisions to terminate their Medicare contracts in certain areas. In some cases, the termination of the contract was the result of a merger between the two plans.

Q3 Can the Health Care Financing Administration (HCFA) force Medicare HMOs to continue their contracts to provide services to Medicare beneficiaries?

A3 No. While HCFA is responsible for ensuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions, nor can we force them to stay in the Medicare program.

Q4 How are HMOs paid by the Federal government?

A4 HCFA pays HMOs a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members. The amounts vary from county to county and are determined based on a methodology prescribed in the statute. HCFA will make monthly payments to plans terminating their contracts through December, 1998. NOTE: $379.84 per month is the lowest Federal government reimbursement rate for the aged allowed for 1999 by the Balanced Budget Act (BBA) of 1997. These rates are only the base rate and the actual payments to HMOs reflect adjustments to the base rate for factors like age, sex, etc.

Q5 Are all HMOs terminating?

A5 No. The changes for January 1999 only affect certain Medicare HMOs and will impact less than 1 percent of the 6 million Medicare beneficiaries enrolled in HMOs. For about 90 percent of beneficiaries whose HMOs are not renewing their contract, there is at least one other managed care option available.

Q6 After an HMO terminates, what health care coverage will be available for Medicare beneficiaries who were enrolled in these HMOs?

A6 Many beneficiaries who are currently members of the terminating HMOs will be able to enroll in other Medicare managed care plans available in their area. Also, the Original Medicare Plan continues to be available to all Medicare-eligible individuals. Beneficiaries who return to the original Medicare plan and wish to purchase a Medicare supplement (Medigap) policy will have specific rights, discussed below. Each terminating HMO should have mailed a list of all health care options to its members by November 2, 1998.

Q7 What options are available for transferring to another managed care plan?

A7 A beneficiary may join another managed care plan if other plans are offered in that area. For about 90 percent of the beneficiaries whose HMOs are non-renewing, there are other plans available. Beneficiaries who choose this alternative before the end date of their coverage will automatically be disenrolled from the non-renewing HMO when they

enroll in the new managed care plan. Before making this decision, beneficiaries should contact the HMO concerning benefits and premiums in order to make the best selection for their personal needs.

The only exception is that a small number of beneficiaries with end stage renal disease (ESRD) who are enrolled in a terminating HMO will be precluded by law from enrolling in a plan offered by another managed care organization. These beneficiaries may enroll in plans offered by the same organization.

Q8 What is Medicare supplemental (Medigap) insurance?

A8 A Medicare supplement policy, also known as Medigap insurance, is a private insurance policy. It is designed to help pay deductibles or coinsurance incurred by beneficiaries who are in the original Medicare plan (also called fee-for-service Medicare). A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the original Medicare plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan. In most states, there are 10 standard Medigap plans, designated by one of the letters "A" through "J," each representing a different combination of benefits.

Q9 Is there anything that will be made available to individuals being terminated from an HMO, such as a Medicare supplemental insurance policy?

A9 HMO enrollees have certain rights to new coverage, but these are time limited. The HMO is required to provide certain information to assist beneficiaries in making decisions about continuing enrollment in another HMO or switching to the original Medicare plan with Medigap to supplement the coverage. In general, individuals who are enrolled with a managed care plan that terminates its contract with Medicare have the right to guaranteed issue of any Medigap plans "A", "B", "C", or "F" that are offered to new enrollees by insurers in the State. (Minnesota, Massachusetts and Wisconsin have special waivers that allow them to provide policies that are comparable to plans "A", "B", "C", and "F".)

Certain Medicare beneficiaries in the terminating HMOs may have another, separate basis for entitlement to guaranteed issue of a Medigap policy. If a person had been enrolled in the HMO for fewer than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medigap policy, that individual may return to the former Medigap policy if the previous Medigap insurance company still sells

the policy in the State.

If coverage is not available under the previous Medigap policy, the individual may purchase Medigap policies "A", "B", "C", or "F" from any insurer which sells these policies in the State.

In either of these situations, the insurance company selling the policy may not:

(1) deny or condition the sale of the policy;

(2) discriminate in the pricing of the policy because of health status, prior history of claims experience, receipt of health care or medical condition; or

(3) impose an exclusion for any preexisting condition.

However, the individual has only 63 days after coverage ends to select a Medigap insurer. Members should contact their State Health Insurance Assistance Program (SHIP) for further information.

See Q11 for specific information regarding beneficiaries under age 65.

Q10 Is there a limit on what Medigap insurers can charge?

A10 The law requires that the premium charged must not be established in a way that discriminates based on health status. This means that insurers cannot consider your health status when determining eligibility or premium levels. Insurers must accept you at the same premium rate provided to otherwise similar applicants with no health problems. Insurers that adjust rates for non-health status factors, such as age or geographic location, can apply those adjustments if done on a nondiscriminatory basis. In general, the states are responsible for determining the limits on what insurers can charge for premiums and for enforcing those limits.

Q11 What health coverage is available for members who are under the age of 65, and eligible for Medicare because of a disability?

A11 Medigap insurers must make any plans designated A, B, C, and F that they currently sell available to any beneficiaries over age 65 whose Medicare managed care plans are terminated. Issuers who currently offer any of these four policies to beneficiaries under 65 who are

entitled to Medicare because of disability or ESRD must also make those policies available to beneficiaries whose HMO terminates.

This provision does not require insurers to offer any plan (A, B, C, or F) that they do not currently sell, nor does it require insurers that do not currently sell policies to beneficiaries under age 65 to begin selling to those individuals. However, it does require the insurers to sell policies to individuals whose HMOs terminated without any underwriting or preexisting condition exclusions.

Terminating HMOs have an obligation to arrange for certain protections against preexisting condition exclusions for beneficiaries who choose to purchase a Medigap policy. However, they must only make these arrangements with respect to Medigap insurance that is available in the local marketplace. Members should contact their local State Health Insurance Assistance Program (SHIP) for further information.

Q12 If Medigap policies are usually sold to beneficiaries under age 65 only on a restricted basis (that is, using medical underwriting), are Medigap insurers required to sell policies to beneficiaries under age 65 whose HMOs are not renewing?

A12 Yes. For example, suppose a Medigap insurer in a particular State usually sells Medigap policies C and F to beneficiaries under age 65 -- but it only sells these policies to healthy beneficiaries who pass medical screening. According to the new rules, this insurer would have to sell these same policies C and F to a beneficiary whose HMO did not renew its contract, without regard to health status and without exclusions for preexisting conditions.

In setting a price, this insurer would have to charge no more than it charges to others buying policies for the first time, and it could not discriminate in price on an individual basis.

Q13 Are Medigap policies sold to beneficiaries under 65 in most States?

A13 At present, our research indicates that in all 30 States (and the District of Columbia) where beneficiaries are affected by HMO non-renewals, at least one insurer is currently selling Medigap policies to beneficiaries under age 65. Some States mandate that insurers selling policies to beneficiaries over 65 also sell to those under 65, while in other states at least some insurers do so on a voluntary basis. In either case, these insurers are required to sell these policies to beneficiaries whose HMOs did not renew contracts without regard to health status and without

exclusions for preexisting conditions.

Although there is no guarantee that these Medigap insurers will continue selling policies in a particular market, at present nearly all beneficiaries should be able to find at least one Medigap policy available for purchase.

Q14 What if a beneficiary dropped a Medigap policy before he or she joined this plan? Can the beneficiary return to this Medigap policy? What happens if the beneficiary returns to the Medigap policy before December 31, 1998?

A14 If a beneficiary was previously enrolled in a Medigap policy and this was the first managed care plan the beneficiary enrolled in since starting Medicare, the beneficiary has the right to return to the Medigap policy if:

1. the Medigap policy dropped is still being sold by the same insurance company;

2. the beneficiary has not been enrolled in this HMO for more than 12 months;

3. the beneficiary disenrolls from this HMO before December 31, 1998; and

4. the beneficiary reapplies for that previous policy no later than 63 days after coverage from this plan terminates.

If the previous policy is no longer available, the beneficiary is still guaranteed the right to buy a Medigap policy designated "A", "B", "C", or "F" that is offered in that State. This applies to beneficiaries who are under age 65 to the extent those policies are made available by insurers in the State. Before the beneficiary disenrolls, he or she should make sure the policy is still available from the original insurer.

Q15 Will members be able to keep prescription drug coverage, or is new coverage being made available?

A15 If a member currently has prescription drug coverage through a terminating HMO, this coverage will also end December 31, 1998. Members have the option to enroll in other managed care plans available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to members of terminating HMOs (plans "A", "B", "C" and "F") do not include prescription drug coverage. Similarly, the requirement that terminating HMOs make certain supplemental coverage available does not require them to make arrangements that include prescription drug coverage. Medicare supplemental plans that contain prescription drug coverage are available, but members must seek them out on their own. These insurers may refuse to sell a policy based on health status, and may impose waiting periods for pre-existing conditions. If you had previous Medigap drug coverage (plans H, I, or J), and leave the HMO within 12 months, you can go back to this policy if the insurer still sells it.

Q16 How soon will a decision need to be made for new health care coverage?

A16 Members may remain enrolled in their HMOs until December 31, 1998, or they may disenroll from their HMOs and return to the original Medicare plan before December 31, 1998. (As noted above, this decision may affect which Medigap options are available). It is recommended that members apply for a Medicare supplemental policy as soon as possible, in order to have Medigap coverage begin when the beneficiary returns to the original Medicare plan on January 1, 1999. However, as long as members apply within 63 days after HMO coverage terminates on December 31, 1998, their rights to get a new Medigap policy will be protected.

Members currently enrolled in an HMO who have Part B only and who wish to enroll in another Medicare managed care plan must do so no later than December 1 in order to ensure they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act created a new "Medicare + Choice" program, with new options for Medicare beneficiaries to choose managed care plans and other health plans as a way to receive their Medicare benefits. However, beneficiaries with Part B-only coverage are not permitted to

enroll in a Medicare + Choice health plan option.

Q17 What are the benefits under the Original Medicare Plan?

A17 Beneficiary focused information, including an explanation of Medicare benefits, is available at <*www.medicare.gov*>.

Q18 Will members be able to go to their same doctors?

A18 For those members returning to the Original Medicare Plan it is very likely that they will be able to continue seeing the same doctors and other providers as they had seen through the HMO. Most physicians also participate in the Original Medicare Plan. Members need to check with their doctor and other providers to find out. If the providers participate in Medicare, there is no need for a change. If a member chooses to enroll in a new Medicare HMO, he or she may need to select a new primary care physician and begin using a new network of providers. Before making a decision to enroll in a new health plan option, the member should check with each managed care plan.

Q19 What happens if a currently enrolled member, who is hospitalized prior to January 1, 1999, is still a hospital inpatient after January 1?

A19 Most beneficiaries who are hospitalized when the HMO terminates its contract with Medicare will continue to be fully covered for all related services. Acute care hospitals in Maryland, and rehabilitation hospitals, psychiatric hospitals, and long-term care hospitals, may be permitted to charge Medicare-approved deductible and copayment amounts if a beneficiary remains hospitalized after the HMO terminates. Members with Medicare supplemental insurance may have these deductible and copayment amounts paid by their Medigap policy.

Q20 What if a currently enrolled member is receiving other services at home? How can he or she receive assistance during this transition?

A20 Members who are currently receiving ongoing care, such as home health care, or who are using medical equipment, such as oxygen or wheelchairs, need to call the phone number shown on their HMO identification card and ask for Utilization Management (UM) when they are ready to change insurance plans. UM will help members make the change to receive care under the Original Medicare Plan or under a

new managed care option. Members who select a new HMO should contact that HMO as soon as possible and ask for the UM department. Members who elect to return to the Original Medicare Plan should instruct their providers to bill Medicare directly after January 1, 1999.

Q21 What happens if a member needs additional information after January 1?

A21 HCFA requires HMOs to provide appropriate assistance to their members for as long as necessary. Individuals can also contact their State Health Insurance Assistance Program (SHIP) for additional assistance.

Q22 Does a current member of a terminating HMO have to wait until January 1, 1999 to change his or her Medicare coverage?

A22 No. If a member chooses to enroll in another Medicare managed care plan prior to January 1, 1999, that enrollment will automatically disenroll the member from his or her HMO. If a member chooses to disenroll and go to the Original Medicare Plan before January 1, 1999, the member must submit a request to disenroll in writing to the plan or go to the local Social Security District Office; disenrollment will be effective at the end of the month in which the plan or Social Security Office receives the request. If the member takes no action, the member will be returned to the Original Medicare Plan on January 1, 1999.

Q23 How can members receive additional assistance or more information about their choices?

A23 Individuals can contact their State Health Insurance Assistance Program (SHIP). The following agencies can also give beneficiaries information on Medicare supplemental insurance plans and help with other health care decisions.

- County Aging Services
- Senior Centers
- Area Agencies on Aging
- State Insurance Departments
- The U.S. Administration on Aging
- HCFA Regional Offices

Fact Sheet on Non-Renewals

Background and General Information on Medicare Health Maintenance Organizations (HMOs) and Non-renewals

- For many years, the law has allowed Medicare to contract with HMOs to enroll beneficiaries. Currently, about 6 million beneficiaries receive their Medicare benefits through Medicare-contracting HMOs. The law that governs Medicare-contracting HMOs through 1998 (the "old" law) is being replaced by a new law that was part of the Balanced Budget Act of 1997. This new law creates the Medicare + Choice program. The Medicare + Choice program allows HMOs as well as other types of health plans to contract with Medicare. Beginning January 1, 1999, if HMOs that had been operating under the old law want to continue their Medicare participation, they must contract under the new Medicare + Choice program. Some currently-contracting HMOs have decided to continue under the Medicare + Choice program; others have decided not to continue their contract.

- Under both the old law and the new Medicare + Choice program, Medicare HMOs must make annual business decisions about whether or not to continue to participate in the Medicare program. A Medicare HMO may make a non-renewal decision to either terminate the Medicare contract completely or to reduce the contract service area (the counties that the HMO serves.)

- For HMOs that want to contract with HCFA to enroll Medicare beneficiaries, HCFA initially approves the HMO and then conducts periodic monitoring reviews. However, HCFA has no control over the annual business decisions of HMOs to continue participating in Medicare, that is, HCFA cannot require HMOs to enter into a Medicare + Choice contract for 1999 or maintain their existing service area under such a contract.

- HMOs that are not renewing their contracts this fall were required to notify HCFA 90 days before the contract ends (i.e., October 2) of a decision to non-renew and to notify affected enrollees 60 days prior to the end of the contract (i.e., November 2 for contracts ending December 31, 1998).

Information for Medicare Enrollees In Non-renewing HMOs

1. **In general.** Non-renewing HMOs will continue to provide services to their Medicare enrollees through December 31, 1998; that is, current enrollees can remain in their HMO through December 31, 1998. They can also disenroll prior to that time and either (1) return to the traditional fee-for-service Medicare program (hereafter referred to as "original Medicare plan"), or (2) enroll in another Medicare-contracting HMO or other Medicare + Choice plan if one is available in their geographic area (see item 3 below on effective dates and exceptions regarding who is eligible to enroll in another plan). All beneficiaries have the option of returning to the original Medicare plan.
Non-renewing HMOs were required to send all affected enrollees an information package by November 2, 1998. This package will provide information on enrollees' options with respect to either (1) returning to the original Medicare plan with supplemental coverage or (2) enrolling in another Medicare-contracting HMO or other Medicare + Choice plan.

2. **Returning to the Original Medicare Plan.** Individuals can return to the original Medicare plan in one of two ways: (1) they can remain enrolled in the non-renewing HMO until December 31, 1998 and be automatically returned to the original Medicare plan starting January 1, 1999; or (2) they can return to the original Medicare plan before December 31, 1998 by submitting a written request to disenroll to the non-renewing HMO, or by contacting a Social Security Office or Railroad Retirement Board Office. The member will be disenrolled effective the first day of the first month following the month the request for disenrollment was made. For example, if the individual requested disenrollment on November 20, he/she will be returned to the original Medicare plan effective December 1, 1998.

   Individuals should understand that, until their disenrollment is effective, they must continue to comply with HMO rules when seeking medical services.

3. **Choosing another Medicare HMO.** Individuals may be able join another Medicare-contracting HMO or other Medicare + Choice plan. Beginning January 1, 1999, beneficiaries can enroll in any Medicare + Choice plan that serves their geographic area if they are entitled to Medicare Parts A and B and do not have permanent kidney failure, as known as End Stage Renal Disease (ESRD). If individuals choose to enroll in another HMO before December 31, 1998, they will automatically be disenrolled from their current HMO. Medicare-contracting HMOs and other Medicare + Choice plans that will be available in their geographic area are required to accept enrollments in November 1998 to be effective January 1, 1999. It should also be noted that some of these HMOs may also accept enrollments during the month of December. Be sure to enroll no later than December 31, 1998 for your coverage to begin on January 1, 1999.

4. **Supplemental insurance through Medigap.**

Requirements for Medigap Insurers:

- With certain exceptions, as long as individuals apply for a Medicare supplemental insurance or "Medigap" policy no later than 63 days after the coverage with the non-renewing HMO terminates, they are guaranteed the right to buy any Medigap policy designated "A","B", "C" or "F" that is offered by insurers in the State. Accordingly, if individuals who remain enrolled until the non-renewing HMO terminates their coverage on December 31, 1998 apply for one of these Medigap policies no later than March 4, 1999, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims experience, receipt of health care or medical condition.

CAUTION: While individuals can apply for a Medigap policy before December 31, 1998, the protections described here will NOT be guaranteed if they voluntarily disenroll before the HMO contract terminates December 31, 1998. Individuals must keep a copy of their HMO's termination letter to show a Medigap insurer as proof of loss of coverage under this HMO. They should also keep a copy of their Medigap application to validate that they acted within 63 days of termination.

- If individuals dropped a Medigap policy to join the non-renewing HMO and they were never enrolled in a similar managed care plan since starting Medicare, they may be able to return to the Medigap policy that was dropped if: (1) the Medigap policy dropped is still being sold by the same insurance company; (2) they disenroll from their current HMO before December 31, 1998; (3) they have been enrolled in their current HMO for no more than 12 months; and (4) they apply for the Medigap policy no later than 63 days after their coverage from their current HMO terminates.

CAUTION: If the previous policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier any Medigap policy designated A, B, C or F that the carrier offers in that State. However, in this situation the 63-day period for filing the new Medigap application will begin on the effective date of the particular beneficiary's disenrollment from the HMO (generally the first day of the month following the month in which the disenrollment is requested).

The individual should therefore make sure the old policy is still available from the original insurer before disenrolling from the non-renewing HMO. If it is not available, the individual will have more time to make a decision about Medigap options by simply remaining enrolled until coverage for all enrolled beneficiaries ends when the HMO's contract terminates on December 31. The individual will then have 63 days from the last day of coverage under the HMO to apply for a Medigap policy designated A, B, C or F.

Requirements for HMOs:

- By law, Medicare HMOs must arrange for individuals to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after a HMO terminates coverage. HMOs will provide individuals with specific information regarding the arrangements that will be made available to beneficiaries in the information package that non-renewing HMOs were required to send by November 2, 1998.

5. **Do these special protections apply to all Medicare beneficiaries?** Medigap insurers must make any policy designated A, B, C, and F that they currently sell available to any beneficiaries over age 65 whose Medicare HMOs are terminated. Issuers who currently offer any of

these four Medigap policies to beneficiaries under 65 who are entitled to Medicare because of disability or ESRD must also make those policies available to beneficiaries under 65 whose HMO terminates.

This provision does not require issuers to offer any policy (A, B, C, or F) that they do not currently sell, nor does it require issuers that do not currently sell policies to beneficiaries under age 65 to begin selling to those individuals. However, it does require the insurers to sell policies to individuals whose HMOs terminated without any underwriting or preexisting condition exclusions.

6. **Supplemental coverage through a former employer.** Beneficiaries who have coverage with a Medicare HMO through their former employer should consult with their former employer's retirement office before making any changes.

7. **Possibility of seeing the same doctor as before.** Beneficiaries who choose to return to original Medicare may be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians also provide services under original Medicare. If there are other Medicare-contracting HMOs or other Medicare + Choice plans in their geographic area, some of their current physicians may also participate with those plans.

8. **Information on other Medicare HMOs.** Comparative information on Medicare-contracting HMOs and other Medicare + Choice plans that have been approved to contract with Medicare for 1999 is available on the Internet at <*www.medicare.gov*> under "Medicare Compare." Information can be accessed by zip code, county, State. Some plans are available only in certain counties within a State or in certain zip codes within a county. Many libraries and senior centers can help beneficiaries obtain information from the Internet.

9. **General assistance for Medicare beneficiaries on health insurance matters.** Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) for assistance; they can also contact the U.S. Administration on Aging (AoA) toll-free number (1-800-677-1116) to be referred to their local area agency on aging.

Questions and Answers for Medicare Beneficiaries Who Lose Managed Care Coverage

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan terminations and service area reductions.

GENERAL QUESTIONS

HMOs are leaving Medicare. How do I get information about whether this is true?

Individuals affected by a termination should have received notification from the HMO no later than November 2, 1998. Information regarding terminations is also posted on Medicare's website at *<www.medicare.gov>*.

Are all HMOs terminating?

No. The changes that have been announced for January 1999 only affect certain Medicare HMOs.

Why are HMOs terminating their contracts with Medicare?

HMOs are independent businesses that make business decisions to either participate or not participate in a contract with Medicare. HMOs voluntarily choose to enter into contracts with the Health Care Financing Administration (HCFA) to serve Medicare enrollees. Each year HMOs have to make a choice to continue their contracts or adjust premiums and/or benefits. Some HMOs have made business decisions to terminate their Medicare contracts in certain areas. In some cases, the termination of the contract was the result of the merger between the two plans where only one corporate entity will continue in the Medicare program.

Can HCFA force Medicare HMOs to continue their contracts to provide services to Medicare beneficiaries?

No. While HCFA is responsible for ensuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions, nor can we force them to stay in the Medicare program.

What happens if your HMO terminates coverage in your area because it does not continue in the Medicare program?

If your HMO will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available to you:

1. You may remain enrolled in the non-renewing HMO until the end of the contract period (i.e., December 31, 1998). If you choose this option, you need take no further action; you will automatically be disenrolled from the HMO and returned to the original Medicare plan as of the effective date of the HMO's termination. Until your disenrollment from the non-renewing HMO is effective, you must continue to use the HMO network of providers.

2. You may join another managed care plan in your area that contracts with the Medicare program. For about 90% of the beneficiaries whose HMOs are nonrenewing, there are other plans available. If you choose this alternative before the end date of your coverage, you will automatically be disenrolled from the non-renewing HMO when you enroll in the new health plan. Health plan(s) in your area that have contracts with Medicare will be identified for you. They are required to accept your enrollment. Contact these plans concerning benefits and premiums in order to make the best selection for your personal needs.

   The only exception is for a small number of beneficiaries with end stage renal disease (ESRD) who are enrolled in a terminating HMO. These beneficiaries are precluded by law from enrolling in a plan offered by another managed care organization. These beneficiaries may enroll in other plans offered by the *same* organization.

3. You may disenroll from the non-renewing HMO and return to the original Medicare plan before your coverage terminates. **(Please read the information below before choosing this option.)** If you choose this option, you may disenroll by notifying the non-renewing HMO. You may also disenroll by writing to or by visiting your local Social Security office or your local Railroad Retirement office if you are a railroad retiree. You will be disenrolled effective the first day of the month following the month in which you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to the original Medicare plan effective December 1.

How soon will a decision need to be made for new health care coverage?

Members may remain enrolled in their HMOs until December 31, 1998, or they may disenroll from their HMOs and return to the original Medicare plan before December 31, 1998. **(As noted below, this decision may affect which Medigap options are available).** It is recommended that members going to the original Medicare plan apply for a Medicare supplemental policy, also known as Medigap insurance, as soon as possible, in order to have Medigap coverage begin when the beneficiary returns to the original Medicare plan on January 1, 1999. However, as long as members apply within 63 days after HMO coverage terminates on December 31, 1998, their rights to get a new Medigap policy will be protected.

There is one additional consideration for a small number of beneficiaries. Members currently enrolled in an HMO who have Part B only and who wish to enroll in another Medicare managed care plan must do so no later than December 1 in order to ensure they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act created a new "Medicare + Choice" program, with new options for Medicare beneficiaries to choose HMOs and other health plans as a way to receive their Medicare benefits. However, beneficiaries with Part B-only coverage are not permitted to enroll in a Medicare + Choice health plan option.

MEDICARE SUPPLEMENTAL INSURANCE

A Medicare supplement policy, also known as Medigap insurance, is a private insurance policy designed to reimburse certain expenses that Medicare beneficiaries incur when services or items covered by the original Medicare plan, also known as fee-for-service Medicare, are not paid in full because of the application of Medicare deductibles or coinsurance. A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the original Medicare plan. It will not cover out-of-pocket expenses, such as copayments, in an HMO.

If I choose to return to the original Medicare plan, can I purchase a Medigap policy?

In most cases, yes. If you return to the original Medicare plan, you may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some of your out-of-pocket costs which are not covered under the original Medicare plan. In addition to Medigap policies which insurance companies must offer you, which are discussed below, your non-renewing HMO has a legal obligation to arrange for you to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the HMO terminates your coverage. The HMO may do this in a number of ways. The HMO must have notified you of arrangements it made for such coverage no later than November 2, 1998.

Some HMOs will identify a specific Medigap insurer, and the insurer will waive (i.e., not apply) the waiting period for coverage of pre-existing conditions. You may then purchase the new policy between specific dates identified by the non-renewing HMO. Your Medigap insurance will have an effective date that should coincide with the ending of the HMO's Medicare contract on December 31 so that you will have continuous coverage.

See below for specific information regarding beneficiaries under age 65.

Are there any protections for a person who chooses a Medigap policy other than the one chosen by the non-renewing HMO?

When the HMO terminates, participants have certain rights, but must exercise them within 63 days after coverage terminates. If a person applies for a Medigap policy within 63 days, the seller or issuer of that policy may not:

(1) refuse to sell the person any Medigap policy designated A, B, C or F that the insurer sells in the State;

(2) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

(3) impose a pre-existing condition exclusion.

Further information is available from each State's insurance department or State Health Insurance Assistance Program.

What if I dropped a Medigap policy before I joined this HMO? Can I return to this Medigap policy? What happens if I do this before December 31, 1998?

If you were previously enrolled in a Medigap policy and this was the first managed care plan you enrolled in since starting Medicare, you have the right to return to the Medigap policy if:

1. the Medigap policy dropped is still being sold by the same insurance company;

2. you have not been enrolled in this HMO for more than 12 months;

3. you disenroll from this HMO before December 31, 1998; and

4. you reapply for that previous policy no later than 63 days after coverage from this plan terminates.

If the previous policy is no longer available, you are still guaranteed the right to buy a Medigap policy designated "A", "B", "C", or "F" that is offered by insurers in your State. This applies to beneficiaries who are under age 65 to the extent those policies are made available in the State. Before you

disenroll, you should make sure the policy is still available from the original insurer.

Is there a limit on what Medigap insurers can charge?

The law requires that the premium charged must not be established in a way that discriminates based on health status. This means that insurers cannot consider your health status when determining eligibility or premium levels. Insurers must accept you at the same premium rate provided to otherwise similar applicants with no health problems. Insurers that adjust rates for non-health status factors, such as age or geographic location, can apply those adjustments if done on a nondiscriminatory basis.

May I shop around for a Medigap policy rather than accept the one chosen by the non-renewing HMO?

Yes. You are free to shop for a Medigap policy that meets your needs and provides coverage you desire at a price you wish to pay.

How do I go about finding a Medigap insurer?

Begin your inquiries as soon as you receive the non-renewing HMO's notice of termination. This way, you will have time to find the best coverage to meet your needs and have it go into effect on the day following the effective date of your non-renewing HMO's termination from the Medicare program.

Your best course of action in such situations is to contact your State insurance department or the State Health Insurance Assistance Program (SHIP). Your SHIP has been trained to assist you in resolving situations like these. The telephone number for the SHIP in your state is available in the *Medicare & You* handbook and bulletin or on the Internet at <*www.Medicare.gov*>. To find out about your SHIP, check the State Government listing in your telephone book, or contact your State's Office on Aging or Insurance Department.

Do these special protections apply to all Medicare beneficiaries, including those under age 65?

Medigap insurers must make any policies designated A, B, C, and F that they currently sell available to any beneficiaries over age 65 whose Medicare HMOs are terminated. Issuers who currently offer any of these four policies to beneficiaries under 65 who are entitled to Medicare because of disability or ESRD must also make those policies available to these beneficiaries whose HMOs terminate.

This provision does not require insurers to offer any policies (A, B, C, or F) that they do not currently sell, nor does it require issuers that do not currently sell policies to beneficiaries under age 65 to begin selling to those individuals. However, it does require the insurers to sell policies to individuals whose HMOs terminated without any underwriting or preexisting condition exclusions.

If Medigap policies are usually sold to beneficiaries under age 65 only on a restricted basis (that is, using medical underwriting), are Medigap insurers required to sell policies to beneficiaries under age 65 whose HMOs are not renewing?

Yes. For example, suppose a Medigap insurer in a particular state usually sells Medigap policies C and F to beneficiaries under age 65 -- but it only sells these policies to healthy beneficiaries who pass medical screening. According to the new rules, this insurer would have to sell these same policies C and F to a beneficiary whose HMO did not renew its contract, without regard to health status and without exclusions for preexisting conditions.

In setting a price, this insurer would have to charge no more than it charges to others buying Medigap policies for the first time, and it could not discriminate in price on an individual basis.

Are Medigap policies sold to beneficiaries under 65 in most States?

At present, our research indicates that in all 30 States (and the District of Columbia) where beneficiaries are affected by HMO non-renewals, at least one insurer is currently selling Medigap policies to beneficiaries under age 65. Some States mandate that insurers selling policies to beneficiaries over 65 also sell to those under 65, while in other states at least some insurers

do so on a voluntary basis. In either case, these insurers are required to sell these policies to beneficiaries whose HMOs did not renew contracts without regard to health status and without exclusions for preexisting conditions.

Although there is no guarantee that these Medigap insurers will continue selling policies in a particular market, at present nearly all beneficiaries should be able to find at least one Medigap policy available for purchase.

OTHER QUESTIONS

Will members be able to keep prescription drug coverage, or is new coverage being made available?

If a member currently has prescription drug coverage through a terminating HMO, this coverage will also end December 31, 1998. Members have the option to enroll in other HMOs available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to members of terminating HMOs (policies "A", "B", "C" and "F") do not include prescription drug coverage. Similarly, the requirement that terminating HMOs make certain supplemental coverage available does not require them to make arrangements that include prescription drug coverage. Medicare supplemental policies that contain prescription drug coverage are available, but members must seek them out on their own. These insurers may refuse to sell a policy based on health status, and may impose waiting periods for pre-existing conditions. Remember, if you had previous Medigap drug coverage (plans H, I, or J), and leave the HMO within 12 months, you can go back to this policy if the insurer still sells it.

Will I be able to go to the same doctors I've been using?

For those HMO members returning to the original Medicare plan it is very likely that you will be able to continue seeing the same doctors and other providers you had seen through the HMO. Most physicians also participate in the original Medicare plan. Beneficiaries need to check with their doctor and other providers to find out. If the providers participate in Medicare, there is no need for a change. If you choose to enroll in a new Medicare HMO, you may need to select a new primary care physician (PCP) and begin using a new network of providers. Before making a decision, you should check with each HMO.

How can I receive additional assistance or more information about my choices?

You can contact your State Health Insurance Assistance Program (SHIP). The following agencies can also give you information on Medicare

supplemental insurance policies and help with other health care decisions.

- County Aging Services
- Senior Centers
- Area Agencies on Aging
- State Insurance Departments
- The U.S. Administration on Aging
- HCFA Regional Offices

Families USA FOUNDATION
The Voice for Health Care Consumers

Fax Transmission

Date: 11/6

Time: _____

Dept. / Activity Code: 30 Project: 90

Number of Pages: 13 (including this cover sheet)

Please deliver this fax to:

Name: Jean Lambrew Org.: _____

Fax #: 456 5557 Phone: _____

Comments: Jean: See p. 12
Note that they are not testing
a demonstration in which SSI
already makes this determination.
They are only testing 3 other weak
schemes. Let's talk

From: Judy Ext.: _____

1334 G Street, NW
Washington, DC 20005
Voice: (202) 628-3030
Fax: (202) 347-2417
e-mail: info@familiesusa.org
Web address: www.familiesusa.org

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4190-29P

SOCIAL SECURITY ADMINISTRATION

Medicare Buy-in Demonstration for Low-Income Medicare Beneficiaries

AGENCY: Social Security Administration

ACTION: Notice, Request for Comments and Solicitation for Demonstration Participation by States

SUMMARY: Title IV of Division A, Social Security Administration, of the Omnibus Consolidated and Emergency Appropriations Act of 1999, Public Law 105-277, directs the Commissioner of Social Security to expend $6,000,000 for Federal-State partnerships which will evaluate means to promote the Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act (the Act).

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Administration of the Medicare buy-in programs described in titles XVIII and XIX of the Act is the responsibility of the Administrator of the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. The Commissioner of Social Security is responsible for the Social Security and Supplemental Security Income (SSI) programs described in titles II and XVI of the Act.

The Medicare and Medicaid programs are statutorily linked to the programs administered by the Social Security Administration (SSA). Because of this linkage, SSA provides certain Medicare- and Medicaid-related services to HCFA, the States and to SSA's beneficiaries. Among these services are public service information activities about the Medicare and Medicaid programs, categorically needy Medicaid eligibility determinations in most States and referral activities for certain Medicaid benefits in all States. The scope of SSA's involvement in the Medicare and Medicaid programs is defined in the Act and in agreements between SSA and HCFA and between SSA and the States.

SSA plans to undertake the demonstration project specified in Public Law 105-277 as a service to SSA's low-income disabled

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beneficiaries and beneficiaries age 65 and over who are or could be entitled to Medicaid benefits to help pay their Medicare costs. SSA intends to investigate the barriers to enrollment of those beneficiaries in the Medicare buy-in programs. SSA is requesting public comment about these plans and soliciting States to express their interest in participating in this demonstration.

DATES: Interested persons are invited to submit comments on or before [30 days from date of publication]. States interested in participating in this demonstration should submit expressions of interest on or before [30 days from date of publication] to the address below.

ADDRESSES: Written comments and expressions of State interest in participation should be addressed to Craig A. Streett, Office of Program Benefits, Social Security Administration, 6401 Security Boulevard, Room 3-M-1 Operations Building, Baltimore, MD 21235, or should be electronically mailed to the internet address Craig.Streett@ssa.gov, or should be faxed to 410-966-0980. All comments and expressions of State interest in

participation received at the internet address will be acknowledged by electronic mail to confirm receipt.

FOR FURTHER INFORMATION CONTACT: Craig A. Streett, (410) 965-9793. Individuals who use a telecommunications device for the deaf (TDD) may call 1-800-325-0778 between 7:00 AM and 7:00 PM, Eastern Time, Monday through Friday.

SUPPLEMENTARY INFORMATION: Section 226 of the Act [42 U.S.C. 426] describes the rules for entitlement to Medicare Hospital Insurance (HI) benefits, also known as Medicare Part A. Generally, Social Security beneficiaries who have attained age 65 are entitled to Medicare Part A benefits without filing an application or other request for those benefits, as are disabled beneficiaries who have received 24 consecutive months of Social Security benefits. Under section 226A of the Act [42 U.S.C. 426-1], certain individuals who suffer from end stage renal disease can also become entitled to Medicare HI benefits. Some individuals may also be entitled to Medicare HI benefits through purchase under the rules in sections 1818 and 1818A of the Act [42 U.S.C. 1395i-2 and 1395i-2a].

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Section 1840 of the Act [42 U.S.C. 1395s] describes the rules for purchase of Medicare Supplementary Medical Insurance (SMI) benefits, also known as Medicare Part B. Generally, Medicare Part B benefits will begin when Medicare Part A benefits begin unless the beneficiary declines the Part B benefits. Usually the beneficiary is responsible for the payment of a monthly premium for Medicare Part B benefits. Section 1843 of the Act [42 U.S.C. 1395v] describes the agreements States may enter into to purchase SMI benefits for some individuals. The purchase of SMI benefits by a State for an individual is referred to as "Medicare Part B buy-in."

Section 1902(a)(10)(E) of the Act [42 U.S.C. 1396a(a)(10)(E)] requires each State's plan for medical assistance to provide for Medicare cost-sharing (including Medicare Part B buy-in) for certain groups of low-income individuals. Some of the groups of low-income individuals are:

1. Qualified Medicare beneficiaries (QMBs). QMBs are individuals who are entitled to Medicaid payment of all their Medicare premiums, deductibles and coinsurance. QMBs must be entitled to Medicare HI benefits (through their own entitlement or by

purchase). QMBs must also have income that does not exceed the Federal poverty level (FPL) after application of the SSI income exclusions, and have resources with values that do not exceed twice the SSI standards after application of the SSI resources exclusions.

2. Specified low-income Medicare beneficiaries (SLMBs). SLMBs are Medicare beneficiaries who would be QMBs but for income which exceeds the FPL but is less than 120 percent of the FPL after application of the SSI income exclusions. SLMBs are eligible for Medicare Part B buy-in.

3. Qualfied individuals-1 (QI-1s). Subject to the availability of funding, QI-1s are Medicare beneficiaries who would be QMBs or SLMBs but for income which exceeds the allowable limit but is less than 135 percent of the FPL after application of the SSI income exclusions. QI-1s are eligible for Medicare Part B buy-in.

For most Medicare beneficiaries, Medicare entitlement is an automatic result of Social Security entitlement when other statutory factors of Medicare eligibility are met. Thus, most

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Medicare beneficiaries also are beneficiaries of the Social Security program administered by SSA. Because of the linkage between Medicare entitlement and Social Security entitlement in title II of the Act and the duties of the Commissioner of SSA in title VII of the Act, both SSA and HCFA have Medicare entitlement responsibilities. In addition, SSA performs additional enrollment and other Medicare-related activities under the auspices of agreements between HCFA and SSA.

Many States have entered into agreements with SSA for SSA to make categorically needy Medicaid eligibility determinations for the State's SSI beneficiaries under the authority in section 1634 of the Act [42 U.S.C. 1383c]. Acting on behalf of States with such agreements, SSA processes Medicare Part B buy-in for SSI beneficiaries who are eligible for this assistance under the rules in section 1843 of the Act.

Although Medicare entitlement usually is a product of the Social Security entitlement process, Medicare Part B buy-in eligibility determinations are a Medicaid process. Under title XIX of the Act, Medicaid is State-administered under the terms of State plans approved by HCFA. SSA plays only a limited role in

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qualifying individuals for Medicare Part B buy-in. SSA does make some buy-in decisions in certain States, but only for SSI beneficiaries. SSA also publicizes the availability of the Medicare Part B buy-in programs in its field offices and through the SSA toll-free number, 1-800-SSA-1213.

A lack of awareness about the Medicare Part B buy-in programs appears to be one of the major obstacles to enrollments. Other obstacles to enrollments have also been suggested, including the confusion of potential eligibles as to how to apply for these programs and a preference for dealing with SSA field offices rather than with State welfare offices.

Because of the low enrollments in the Medicare Part B buy-in programs, SSA proposes to conduct a Medicare Part B buy-in demonstration as a service to assist our beneficiaries. The two-part demonstration will be designed to identify and overcome the obstacles to Medicare Part B buy-in enrollments for QMBs, SLMBs and QI-1s. SSA intends to implement both internal and external components of the demonstration, and SSA invites States to form Federal-State partnerships with SSA to participate in this demonstration. However, in order to avoid skewing the data

derived from the demonstration, SSA would prefer that only those States participate in the external component of the demonstration who are not already working with HCFA on that agency's initiative to encourage and promote enrollments for the Medicare Part B buy-in programs.

As currently envisioned, the internal component of the demonstration would involve increased Medicare Part B buy-in referral activities by SSA employees when contacted by Medicare-entitled beneficiaries. An example of this type of increased referral activities may be eligibility screening and subsequent direct notification of Medicaid State agencies when a Social Security beneficiary appears to be potentially eligible for Medicare Part B buy-in. Currently, SSA suggests that beneficiaries get in touch with the Medicaid State agency to discuss eligibility for Medicare Part B buy-in without identifying those beneficiaries to the State.

Medicare-entitled Social Security beneficiaries routinely contact SSA for a number of reasons, such as reports of the death of a spouse. When informed of a spouse's death, SSA recomputes the widow(er)'s benefit to determine if the widow(er)

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might be entitled to a larger monthly benefit. In all States, SSA could use these contacts to screen carefully for potential Part B buy-in eligibility and both refer the caller to the Medicaid State agency and provide identifying information about potential Medicare Part B buy-in eligibility to the Medicaid State agency for State-initiated followup.

The external component of the demonstration would involve Federal-State partnerships. State partners that wish to participate in the demonstration would volunteer ZIP codes that relate to areas within each State with a high proportion of low-income aged and disabled Medicare beneficiaries who could be, but are not, eligible for the Medicare Part B buy-in programs. State participants would join with SSA in publicizing this demonstration in the targeted communities. Some State partners also would be involved in educating SSA employees about the State welfare Medicare buy-in application process, and/or providing welfare workers who would be assigned to take applications in SSA field offices at certain mutually agreeable, fixed times during the demonstration.

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SSA expects to implement the external part of this demonstration in no more than 15 communities. That is, SSA and its State partners would identify three sets of up to five comparable communities in several States. Each set of five comparable communities would be selected to participate in each of the following three models:

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1. Screening - Publicity would direct Medicare beneficiaries who may be potentially eligible for Medicare Part B buy-in to contact a toll-free telephone number staffed by SSA employees. SSA staff would perform an in-depth Medicare Part B buy-in eligibility screening if at all possible while the caller is on the telephone. Potential eligibles would then be referred to the State welfare office to file applications for benefits, and SSA would track the progress of those applications with the State partner.

2. Co-location - In addition to the publicity and screening efforts cited in the preceding model, potential Medicare Part B buy-in eligibles also would be invited to file an application for benefits with a State welfare worker stationed (for at least some fixed part of the week) at the local SSA office.

3. Application - In addition to the publicity and screening efforts cited in the preceding two models, potential Medicare Part B buy-in eligibles would be invited to file an application for those benefits, completing the appropriate forms at the local SSA office.

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SSA does not envision all three of these models starting at exactly the same time. Federal information collection clearance procedures, training, logistical details and mutual convenience for both the Federal and State partners will dictate starting dates. SSA expects these models to end within nine months after implementation.

SSA intends to employ an independent contractor to consult on the design of the demonstration and to conduct an evaluation of the net outcomes (e.g., increased applications to and enrollments in the buy-in programs) of the demonstrations. The role of the contractor in the design phase of the demonstration will be to advise SSA on how to implement the three models described above. SSA field offices will be responsible for collecting data and other SSA components will develop the management information system. The contractor will assist SSA and the States in specifying key data elements to enhance data comparability across sites. This system may include existing SSA administrative data as well as data collected through the demonstration. Designs that the contractor will consider include both experimental and nonexperimental approaches. An

experimental design might involve a random assignment of cases to treatment and control groups, while a nonexperimental design could include the collection of analogous data from comparison sites. Each has important implications for the implementation of the three models and for the development of the management information system. State partners will be expected to cooperate with the contractor at key points of the design and evaluation activities. Both the internal and external components of this demonstration will be designed to avoid duplicating any other Federal efforts.

The evaluation component will include analyses of the relative effectiveness of the three models in terms of increasing Medicare Part B buy-in applications from the eligible population and increasing enrollments in the buy-in programs. The evaluation also will include a comparison of buy-in program applications and enrollments under the SSA interventions versus HCFA publicity efforts. An appropriate design is critical to proper measurement of increases in Medicare Part B buy-in enrollments.

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SSA invites the public to comment on its proposed demonstration design. SSA also invites States to join in this demonstration. State partners in the demonstration may be asked to implement any or all of the models described above; however, if a State that wishes to participate would prefer participation in less than all three models, those preferences will be honored to the extent possible.

Authority: Division A, Title IV of Public Law 105-277.

Dated:

Kenneth S. Apfel

Commissioner of Social Security