NORTH DAKOTA
DEPARTMENT OF INSURANCE

SENIOR HEALTH INSURANCE COUNSELING PROGRAM

NORTH DAKOTA

a program of the North Dakota Insurance Department

SHIC

Senior Health Insurance Counseling

TRAINING MANUAL

This manual is the property of the North Dakota Department of Insurance.

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SHIC MISSION STATEMENT

The North Dakota Senior Health Insurance Counseling (SHIC) program will provide education, review, support, and referral services regarding federal, state, and individual health insurance programs and contracts to Medicare beneficiaries of North Dakota.

Introduction

Thank you for your interest in the North Dakota Senior Health Insurance Counseling program and **congratulations** on your decision to volunteer.

Over the next few days, you will receive training and information that will enable you to help senior citizens:

1. **Understand Medicare** and private insurance policies.

2. **Know their rights** and opportunities in the area of health insurance.

3. **Make decisions** about the kinds and amounts of coverage they need.

4. **Evaluate** the health insurance policies available to them.

5. Know where to go for other needed services.

Your commitment can really make a difference in the lives of older citizens in our state. **Thank you and good luck!**

The Department

INSURANCE DEPARTMENT MISSION STATEMENT

The North Dakota Insurance Department is a team of dedicated professionals who constantly strive to improve our effectiveness and efficiency in protecting the public.

We assure that consumers receive fair policies at reasonable prices and that companies honor their obligations to their customers while adhering to strict solvency standards. We also serve the public by providing special insurance, safety, environmental protection, and educational programs.

There are a number of different divisions involved in the Department's goal of ensuring that consumers receive **fair value and service** from insurance carriers.

1. The **Administration Division** handles personnel, accounting, information technology issues, support, and day-to-day operations.

2. The **Examination and Company Licensing Division** monitors the fiscal practices and overall soundness of domestic (North Dakota-based) insurers and oversees company licensing.

3. The **Legal/Enforcement Division** oversees legal issues and plays a primary role in developing legislation and reviewing insurance-related issues at the state and national level.

4. The **Special Funds Division** administers special insurance-related funds established by the Legislative Assembly including the Fire and Tornado Fund, Petroleum Tank Release Fund, Bonding Fund, Boiler Inspection Program, and Anhydrous Ammonia Program.

5. The **Consumer Protection Life/Health Division encompasses Senior Health Insurance Counseling and Prescription Connection for North Dakota**. It includes analysts who review life and health insurance policy forms and rate filings and investigate complaints related to these types of insurance. The consumer hotline staff are also part of this division.

6. The **Consumer Protection Property/Casualty Division** reviews property and casualty insurance policy forms and rate filings and investigates complaints related to these types of insurance.

7. The **Agent Licensing and Investigation Division** oversees agent licensing and agent continuing education. This division also handles complaint investigations and works closely with the Legal Division when investigations result in prosecution.

Senior Health Insurance Counseling

The **Senior Health Insurance Counseling** (SHIC) program was formally initiated in January 1993. SHIC is funded by a grant from the **Centers for Medicare and Medicaid Services (CMS)**, a division of the federal Department of Health and Human Services. CMS is the agency that administers Medicare.

The SHIC program seeks to make Medicare beneficiaries more knowledgeable users of government health insurance programs and more informed consumers of private insurance programs.

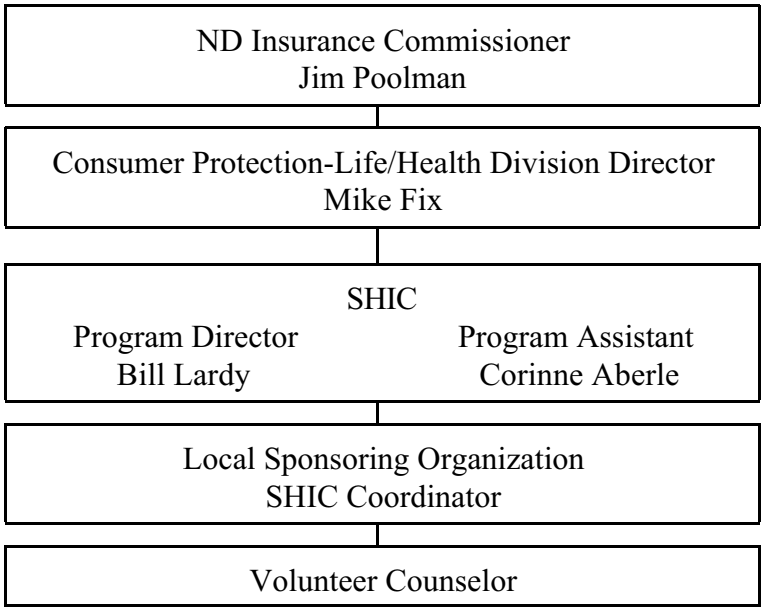
The SHIC program is a **public-private-volunteer partnership** between the Department, sponsoring organizations, and volunteers.

1. **The Insurance Department** administers the program, providing technical training and support; overseeing federal reporting requirements; and developing statewide promotion options.

2. **Local sponsors** coordinate the activities of volunteer counselors, providing general support as needed; maintaining local client files; and developing local promotion options.

3. **Local volunteer counselors** provide direct assistance to Medicare beneficiaries with health insurance problems; report their contacts and activities to the Insurance Department program staff and maintain their knowledge and skills by reading the bimonthly newsletter and other mailings and by attending regularly scheduled update training sessions.

SHIC ORGANIZATIONAL CHART



SHIC Staff

The SHIC director and staff are responsible for:

1. **Recruiting sponsors**.

2. Coordinating and conducting **training sessions**.

3. Developing and coordinating **statewide publicity** and advising or assisting with local publicity.

4. Providing counselors and consumers with **resource material**.

5. Presenting public forums on Medicare and senior health insurance issues.

6. Documenting service needs and program progress for **reporting to CMS**.

7. Answering consumer questions that come into the Insurance Department about Medicare, Medicare

supplement, long-term care, and other senior health-related insurances when hotline staff get behind.

Local Sponsors

The sponsor is responsible for:

1. **Assisting with arrangements** for training/update sessions. Sponsors and/or staff assigned to coordinate the program should attend all training and update sessions.

2. **Coordinating client** contacts. When a client contacts a sponsor, the sponsor gathers enough information to make a referral/appointment for a counselor.

   As necessary, the sponsor then provides **space** (i.e., private meeting room), **supplies** (i.e., paper, pen, envelopes), and **services** (i.e., copying, mailing, telephone) for the counselor to carry out their assigned case.

   NOTE: Questions or concerns about the cost of supplies or services due to an unusually complex case should be discussed with the SHIC program staff as soon as possible after they arise.

3. **Promoting** the program. Sponsors are encouraged to promote the program through low cost or no cost means. Examples include talk shows, newsletters, fliers, PSAs, posters, and brochures. Resource material and other assistance can be provided by the Department.

Counselors

Counselors are responsible for:

1. **Completing the initial** training session. Counselors must attend the full training session before they will receive certification.

2. **Providing direct assistance.** Counselors will follow up on assigned calls within 24 hours or as soon as possible.

The counselor uses his/her judgment on how to proceed with each client based on the information received from training sessions and materials. This may include sorting paperwork, making telephone calls, writing letters, setting up additional appointments, or referring the client to another agency.

Reference materials include: SHIC training manual; Medicare and You; Guide to Health Insurance for People With Medicare; Medicare Supplement Premium Comparisons; North Dakota Medicare Supplement and Long-Term Care Insurance Approved Policy Lists; Long-Term Care Insurance Shopper's Guide as well as access to CMS's website at www.cms.hhs.gov and the North Dakota Insurance Department website, www.state.nd.us./ndins.

If the case requires large amounts of copying or supplies, volunteers should consult the sponsor about the needs. Mileage is also available for cases requiring out-of-town travel.

3. **Recordkeeping.** For each client contact, the counselor completes a Client Contact Form. At the end of each month, these are submitted to the Insurance Department in postage paid envelopes provided.

4. **Attending** update sessions. Counselors are required to attend at least one update session each year. Updates are an opportunity to ask questions, gather new information and network with other volunteers.

   Scheduling is done at least six weeks in advance to make fulfilling the attendance requirement easier. A reminder is sent two weeks in advance.

   Counselors are also asked to work with the sponsoring organization to promote the SHIC program in the local community.

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

SHIC VOLUNTEER COUNSELOR JOB DESCRIPTION

Purpose of Position: To provide health insurance information, counseling assistance, and referral services to Medicare beneficiaries, their families, and caregivers.

Responsible to: Sponsoring organization's coordinator for the North Dakota Senior Health Insurance Counseling program and Insurance Department SHIC staff.

Responsibilities:

Satisfactory completion of Senior Health Insurance Counseling program initial training. Signing the Volunteer Agreement indicates you feel prepared to provide counseling assistance.

Provide health insurance counseling services without conflict of interest and in compliance with SHIC program guidelines.

Conduct individual counseling sessions:

- Assess client's need for information and/or assistance.
- Provide Medicare, supplement, and long-term care insurance information and prescription drug assistance programs.
- Assist with Medicare and other health insurance claims filing, appeals, and/or referrals.
- Provide informal claims advocacy as required.
- Provide referrals to appropriate resources.

File reports and provide follow up as required.

Handle client information in strictest confidence.

Satisfactorily complete continuation training as required by the SHIC program.

Desired Qualifications: Ability to get along with others; sensitive and caring attitude; willingness to learn about and ability to retain information relevant to health insurance provisions and claims filing procedures; good written and oral communication skills.

Time Commitment: Volunteers hours as agreed upon by the counselors and sponsors. Time necessary to handle cases assigned.

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

SPONSORING ORGANIZATION'S COORDINATOR JOB DESCRIPTION

Purpose of Position: To develop, supervise, and support a group of volunteer counselors who provide health insurance information and health insurance counseling; to assist in publicizing the program; provide consumer education.

Responsible to: Sponsoring organization and Senior Health Insurance Counseling Program staff.

Responsibilities:

Maintain a roster of trained counselors.

Provide liaison between counselors, the sponsoring organization, and the North Dakota Insurance Department.

Meet with counselors, periodically (bi-monthly recommended; no less than quarterly), to discuss counseling activities, review reporting activities, and discuss potential marketing opportunities.

Maintain client files.

Assist in coordinating local publicity.

Act as a clearinghouse for training materials, supplemental information, forms, and reporting documents.

Assist program staff in the development of procedures to monitor the effectiveness of counselor activities.

Attend training and other meetings and conferences related to program operation.

NORTH DAKOTA CENTURY CODE

26.1-02-24.3. Insurance counseling programs – Volunteers - Immunity from liability.

A person who, on a volunteer basis, provides services or performs duties on behalf of the commissioner of insurance for an insurance counseling program is immune from civil liability for any act or omission resulting in damage or injury if at the time of the act or omission the person who caused the damage or injury was acting in good faith, in the exercise of reasonable and ordinary care, and in the scope of that person's duties as a volunteer and the act or omission did not constitute willful misconduct or gross negligence. This section does not grant immunity to a person causing damage as a result of the negligent operation of a motor vehicle.

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HIPAA FACT SHEET

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided the Department of Health and Human Services (HHS) with the authority to craft privacy protections by regulation. HHS issued the regulation, "Standards for Privacy of Individually Identifiable Health Information," (Privacy Rule) on December 28, 2000, with modifications published on 8/14/02. The rule became effective on 4/14/01. Most covered entities had until 4/14/03 to come into compliance with the regulation.

The Privacy Rule provides the first comprehensive federal protection for the privacy of health information. While federal agencies that hold individually identifiable information are subject to the Privacy Act of 1974, the HIPAA Privacy Rule extends privacy protections to the private sector as well. Additional information on the federal privacy standards, including the final rule, may be found at 45 CFR Part 160 and 164, 65 Federal Register 82462 as amended by 66 FR 12434 or at http://www.hhs.gov/ocr/hipaa/. The Office of Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation.

The privacy provisions of the federal HIPAA law apply to health information created or maintained by covered entities, which are defined as health plans, health care clearinghouses, and health care providers who engage in certain electronic transactions. As a health plan, Medicare is the covered entity. The State Health Insurance Assistance Program (SHIP) employees and volunteers do not meet the definition of a covered entity under the Privacy Rule and, therefore, are not subject to the provisions of the rule.

The Privacy Rule extends certain protections to the business associates of a covered entity. By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information <u>on behalf of a covered entity</u>. Although the SHIP employees and volunteers work under a grant from CMS, they are not business associates of the Medicare program since the work they do involving protected health information is <u>on behalf of the beneficiary</u>, not the covered entity.

Not withstanding the above clarification, your state laws governing privacy are still applicable to SHIPs. The CMS SHIP grant terms and conditions are provided as requirements for safeguarding any information related to the Medicare beneficiary as a matter of responsible conduct of SHIP grantees. However, as stated above, any additional regulations that are state-specific may apply accordingly.

For any state specific questions, please contact your State Office on Privacy.

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Jim Poolman
Commissioner of Insurance

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

VOLUNTEER IN-FORMATION FORM

Name _____ M( ) F(1

Sponsoring Organization _____

Mailing Address _____ City _____ Zip _____

Telephone _____ Date of Birth _____

Email Address _____

BACKGROUND INFORMATION

Education:

_____

_____

_____

Paid Work Experience:

_____

_____

_____

Volunteer Work Experience:

_____

_____

_____

Special Interests or Hobbies:

_____

_____

_____

600 E. BOULEVARD AVE DEPT 401 ▪ BISMARCK ND 58505-0320 ▪ (701) 328-2430 • FAX (701) 328-4880
Consumer Hotline: 1-800-247-0560 * Relay North Dakota: 1-800-366-6888 (TTY)
Website: www.state.nd.us/ndms

Jim Poolman
Commissioner of Insurance

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

VOLUNTEER AGREEMENT/NO CONFLICT OF INTEREST

I, _____, agree to serve as a volunteer for the Senior Health Insurance Counseling program working through _____ _____ (sponsoring organization). I do not have an active insurance license. I have no interest in or affiliation with any insurance agency, company, or product.

I understand my volunteer services may include acting as a teacher, counselor, presenter, or general resource person for Medicare beneficiaries and caregivers with respect to insurance-related matters covered in the SHIC training sessions. I will provide services in a professional and objective manner.

In the course of my volunteer services, I will NOT recommend, suggest, propose, or otherwise advise the purchase, sale, renewal, termination, or nonrenewal of any particular insurance product or insurance provider to any client or group of clients.

I will not disclose or use confidential information obtained as a result of my association with or access to any client for personal gain or advantage for my employer, or for any other parties, or for any purpose not directly required by this insurance counseling program.

I recognize my obligation to respect the confidentiality of the client and to exercise good faith, integrity, and my best judgment in all dealings with clients as a SHIC counselor.

I understand I must participate in at least one Senior Health Insurance Counseling education program each year to continue as a counselor. I understand and agree to adhere to all policies and guidelines of the Senior Health Insurance Counseling program.

_____ _____
Date Signature

_____
Address

_____
Telephone

600 E BOULEVARD AVE DEPT 401 • BISMARCK ND 58505-0320 • (701) 328-2440 • FAX (701) 328-4880
Consumer Hotline: 1-800-247-0560 • Relay North Dakota: 1-800-366-6888 (TTY)
Website: www.state.nd.us/ndins

3/2004

Jim Poolman
Commissioner of Insurance

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

MEMORANDUM OF UNDERSTANDING WITH

(Sponsoring Organization)

A. The Sponsoring Organization will:

- Adopt, for the purposes of providing this service, the official title of the North Dakota Senior Health Insurance Counseling (SHIC) program.
- Recruit volunteers. No person who is employed by or associated with any organization marketing insurance products may participate in this program in any capacity.
- Protect client confidentiality by securing records and assisting counselors in doing so.
- Appoint a properly qualified individual as Coordinator of Counselor Activities.
- Assure coordinator attends training and other meetings relevant to the program.
- Assure volunteers have received required training.
- Receive client telephone calls and schedule counseling appointments.
- Provide suitable space for training and counseling.
- Provide telephone, copying service, office supplies, and required postage.
- Serve as a clearinghouse for counselor supplies/materials.
- Assure coordinator meets with counselors to discuss counseling activities.
- Publicize the counseling program.

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Consumer Hotline: 1-800-247-0560 • Relay North Dakota: 1-800-366-6888 (TTY)
Website: www.state.nd.us/ndins

3/2004

B. The North Dakota Senior Health Insurance Counseling Program Office will:

- Provide job descriptions for counselors and coordinators.
- Insure that initial and continuing training are provided to counselors.
- Provide training and information materials.
- Assist with publicity and counselor recognition.
- Provide certificates and identification cards for counselors.
- Compile data and provide periodic reports to the sponsoring organization concerning program activities.

This Agreement will continue in effect until amended or terminated by either party with 30 days notice.

SPONSORING ORGANIZATION'S AUTHORIZED REPRESENTATIVE:

_____	_____	_____
Name	Signature	Date

STATE PROGRAM REPRESENTATIVE:

_____	_____	_____
Name	Signature	Date

In Accordance with Standards and Policies of

NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

_____
(Name of Coordinator)

Is hereby Appointed Coordinator of Counselor Activities
For

_____
(Name of Sponsoring Organization)

The purpose of the Coordinator's position is to develop, supervise and support volunteer counselors trained by the Senior Health Insurance Counseling (SHIC) Program; to assist in publicizing the SHIC program, and to assist in providing consumer education.

The Coordinator is responsible to the Sponsoring Organization and Senior Health Insurance Counseling program staff.

Coordinator responsibilities include:

- Maintain a roster of trained counselors.
- Provide liaison between counselors, the Sponsoring Organization and the Senior Health Insurance Counseling program staff.
- Meet with counselors periodically (bi-monthly recommended; no less than quarterly) to discuss counseling activities, review reporting activities and discuss potential marketing opportunities.
- Maintain client files.
- Assist in coordinating local publicity.
- Act as a clearing house for training materials, supplemental information, forms and reporting documents.
- Assist SHIC program staff in developing procedures to monitor effectiveness of counselor activities.
- Attend training and other meetings and conferences related to the SHIC program operation.

SPONSORING ORGANIZATION'S AUTHORIZED REPRESENTATIVE

Name	Signature	Date

COORDINATOR

Name	Signature	Date

Address

Telephone	Email

3/2004

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NORTH DAKOTA SENIOR HEALTH INSURANCE COUNSELING PROGRAM

CLIENT AGREEMENT AND AUTHORIZATION

The Senior Health Insurance Counseling (SHIC) program is administered by the North Dakota Department of Insurance with federal grant funds from the Centers for Medicare and Medicaid Services. I understand the following provisions and agree to counseling provided by a North Dakota Senior Health Insurance Counselor.

I understand the trained volunteer counselors will provide assistance and information including:

- Review of Medicare supplement, long-term care, and other health insurance plans
- Coverage and claims conflicts
- Sorting out bills, reimbursement, and benefit statements
- Referral to other agencies when necessary.

Whenever possible, the volunteer counselors will provide me with the skills and tools to manage future information and claims on my own.

I understand volunteer counselors will not advocate or make decisions about my health insurance or promote any products or policies for sale. I understand the advice offered by program volunteers is NOT legal advice and that I may need to consult an attorney, accountant, government office, public service agency, family members, or other information resource before making final decisions.

The SHIC program, its volunteer counselors, and sponsors are not liable for decisions I make based on information or assistance provided and I agree to hold harmless the program, its sponsors, and volunteers. The Department may contact me at a later date to evaluate the service.

_____
Client Initials

All services are free and confidential.

I hereby authorize the program and/or the below named individual to receive and transmit information as necessary from/to my hospitals, physicians, and/or other providers of medical services or supplies as well as Medicare carriers and intermediaries and my private insurance companies. Unless restricted below, this authorization shall remain valid for 365 days from the date of signature and shall apply to all claims filed on my behalf in the past, present, or future.

Beneficiary Name _____ Medicare I.D. _____

Counselor Name _____ Claim Number _____

Birthdate _____

Information to be Released: _____ Claim _____ Records _____ Other _____ One Time _____Ongoing

_____ _____

Beneficiary Signature Date Counselor Signature Date

Address/Phone _____ Address/Phone _____

_____ _____

Valid for one year from date signed - White copy to client file; yellow copy to client

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

Noridian Administrative Services
Medicare *Part B* Release of Information Request

This is an Authorization for Release of Information form. Your signature on this form authorizes Medicare to release information to the person, agency, company or organization that you name below to Act On Your Behalf. The form will be on file for future Telephone, Written Correspondence, or Appeal Requests. Please be aware, the form is not valid unless you sign and date it. An * indicates the fields that you are required to complete. Please complete all * fields before returning to our office.

BENEFICIARY INFORMATION (Person with Medicare)

*Name: _____ *Medicare Number _____
(From your Red, White and Blue Medicare Card)

*Date of birth: _____ *Telephone number: _____

*Address: _____ *City _____ *ST _____ *Zip _____

*** Reason Why You are Filling Out This Request** (Please check one):
☐At Request of the Beneficiary
☐Other (Specify Reason): _____

_____

***Type of Information to be released** (Please check one):
☐Release ALL Information
☐Specific Information to be released: _____

_____

***Time Frame:** (Please check one):
☐On-going release
☐Limited (give date range) _____ to _____

Person, agency, company or organization to which you are authorizing Medicare to disclose your personal medical information:

*Name: _____

*Address: _____ *City _____ *ST _____ *Zip _____

*Telephone number: _____

I authorize the use of a copy (including electronic copy) of this form and the disclosure of my personal medical information described above. I understand refusal to authorize disclosure of my personal medical information will have no effect on my treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

_____ _____

***Signature of Beneficiary or Authorized Representative** ***Date**

If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation. (For example, Power of Attorney or Appointment of Representative)

Please Note:

This Release of Authorization Request allows Medicare to disclose information from your records to the requested person, agency, company or organization that you authorized. Therefore, the information disclosed pursuant to the authorization may be re-disclosed by the recipient and may no longer be protected by law.

You also have a right to revoke this Release of Information Request by contacting our office in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to the address below.

If you have any questions regarding this form please contact us at:

AK, AZ, HI, NV, OR, WA: 1-800-444-4606
CO: 1-800-332-6681
IA: 1-800-532-1285
ND: 1-800-247-2267
SD: 1-800-437-4762
WY: 1-800-442-2371

Return to:
Noridian Mutual Insurance Company
A CMS Contracted Carrier/Intermediary
4305 - 13th Avenue South
Fargo, ND 58103

Senior Health Insurance Counseling (SHIC) Client Contact Form

Counselor Name:	Date of Client Contact:	Type of Contact: ☐ Telephone ☐ In-Person (site) ☐ In-Person (home visit) ☐ e-mail/fax
Sponsor Name:	Dates Contact Attempted: (optional)	
Sponsor #:		

SECTION 1 - CLIENT INFORMATION

Beneficiary Name (required):		Type of Client: ☐ Beneficiary (self) ☐ Couple ☐ Caregiver (family member, conservator) ☐ Agency
Address:		
Zip Code (required):	Telephone # (required): ( )	

Name of Client Representative and contact information (if different from beneficiary):

Summary of questions or problems needing assistance and counselor action or resolution:

☐ Mailed written materials

SECTION 2 - BENEFICIARY DEMOGRAPHICS: Is this his/her first visit since October 1, 1999?

☐ Yes (complete this section) ☐ No (skip to Section 3)

Date of Birth: _____ or Age: ☐ < 65 years ☐ 65 - 74 ☐ 75 - 84 ☐ 85 or older ☐ Not Collected	Gender: ☐ Female ☐ Male ☐ Not Collected	Ethnicity/Race: ☐ American Indian or Alaska Native ☐ Black or African-American ☐ Hispanic or Latino ☐ Asian, Native Hawaiian, or other Pacific Islander ☐ White, not of Hispanic origin ☐ Other:_____ ☐ Not Collected
Monthly Income: ☐ ≤ SLMB rate (individual=$844, couple=$1,126) ☐ > SLMB rate ☐ Not Collected	Disabled: ☐ Yes ☐ No ☐ Not Collected	

SECTION 3 - TOPICS DISCUSSED

Medicare:	$	Medigap/Supplement/SELECT:	$
☐ Enrollment, eligibility, benefits, options	☐	☐ Enrollment, eligibility, comparisons	☐
☐ Claims/billing	☐	☐ Change coverage/Medicaid suspension	☐
☐ Appeals/quality of care	☐	☐ Reduce coverage	☐
☐ Disability	☐	☐ Cancel coverage	☐
☐ Fraud/abuse	☐	☐ Claims/appeals	☐

Medicare+Choice (HMOs, managed care):	$	Long-Term Care Insurance:	$
☐ Enrollment/disenrollment, eligibility, comparisons, disability, etc.	☐	☐ Compare/explain	☐
☐ Plan or benefit changes/non-renewals	☐	☐ Change coverage	☐
☐ Appeals/quality of care/grievances	☐	☐ Reduce coverage	☐
		☐ Cancel coverage	☐
		☐ Claims/appeals	☐

Medicaid:	$	Other:	$
☐ Regular Medicaid	☐	☐ Employer health plan or FEHB	☐
☐ Medically Needy Medicaid	☐	☐ Other health insurance	☐
☐ Dual eligible	☐	☐ COBRA	☐
☐ QMB	☐	☐ Military health benefits	☐
☐ SLMB/QI-1	☐	☐ Prescription assistance/plans	☐
☐ QI-2	☐	☐ Free or sliding fee care	☐
☐ LTC/home & community-based waivers (HCBS)	☐	☐ Customer service issues	☐
☐ Nursing home/spousal impoverishment	☐	☐ Complaint	☐
☐ SSI	☐	☐ Other:_____	☐

SECTION 4 - CASE SUMMARY (Attach additional pages if necessary)

Actual Savings to Client: $_____

Referrals to:

- ☐ Social Security Administration
- ☐ Legal Services
- ☐ Department of Insurance
- ☐ County Social Services
- ☐ Other_____

Time Spent:

- ☐ Less than 15 minutes
- ☐ 16 minutes to 1 hour
- ☐ 1 to 2 hours
- ☐ 2 to 4 hours
- ☐ More than 4 hours:_____

P.2

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME (Print or Type)	H.I. CLAIM NUMBER

SECTION I APPOINTMENT OF REPRESENTATIVE

I appoint this individual: _____
(Print or type name and address of individual you want to represent you)

to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this individual to make or give any request or notice; to present or to elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead.

SIGNATURE (Beneficiary)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Centers for Medicare & Medicaid Services; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section III (optional) satisfies this requirement).

I am a / an _____
(Attorney, union representative, relative, law student, etc.)

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION III (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing _____ _____ before the Social Security Administration or the Centers for Medicare & Medicaid Services.

SIGNATURE	DATE

(See important information on reverse)
FORM CMS-1696-U4 (10-84)

An attorney, or other representative, who wishes, to charge a fee for services rendered in connection with a claim before the Social Security Administration is required by law to obtain approval of the fee from the Social Security Administration or the Centers for Medicare & Medicaid Services (section 206(a) and 1631(d)(2) of the Social Security Act; sections 404.1720 and 416.1520 of the Social Security Administration Regulations Nos. 4 and 16, respectively). If the representative wishes to waive a fee or to waive direct payment of the fee from past-due Social Security benefits, he may do so. Section III on the front of this form can be used for that purpose.

The form SSA-1560-U4, "Petition to Obtain Approval of a Fee for Representing a Beneficiary before the Social Security Administration," elicits the information required to be submitted in support of fee petitions. It should be completed by the representative after services are completed and the original and the third carbon copy of the SSA-1560-U4 filed with the office of the Social Security Administration or the Centers for Medicare & Medicaid Services which took the latest action on the claim. The representative is required to furnish the "Claimant's/Beneficiary's Copy" of the SSA-1560-U4 petition to the claimant for whom the services were rendered.

Social Security Administration approval of a fee is *not* required where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question, (2) in representing the beneficiary before a court of law, or (3) in representing the beneficiary in a claim for reimbursement of medical expenses exclusively handled by a private intermediary. Where a representative has rendered services in a claim before the Social Security Administration and a court of law, the regulations require that the amount of the fee to be charged, if any, for services performed before the Social Security Administration be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted. In this connection a claim which has been remanded by a court to the Social Security Administration for further administrative proceedings is considered to be before the Social Security Administration after the remand by the court.

AUTHORIZATION OF FEE

The social security regulations contemplate that a representative will receive fair value for the services performed before the Social Security Administration on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the Social Security Administration or the Centers for Medicare & Medicaid Services considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the claim and the amount of the fee requested by the representative. When a fee is authorized, both the representative and the claimant are notified and allowed 30 days in which to request an administrative review in case of disagreement.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States.

DOCUMENT REFERENCE SHEET

Received By	Date	Received From	Document Description	Date Returned	Initials

DOCUMENT REFERENCE SHEET

Received By	Date	Received From	Document Description	Date Returned	Initials

CLAIM INFORMATION SHEET

Name _____

Year _____

					MEDICARE			PRIVATE INSURANCE			
					HIC #_____		COMPANY_____		POLICY #_____		
Date of Service	Provider	Unassigned & Assigned	Amount Billed	Maximum Limit	Amount Approved	Amount Paid	Balance Due	Date Submitted	Amount Paid	Date Paid	Amount Not Covered

CLAIM INFORMATION SHEET

Name _____

Year _____

					MEDICARE			PRIVATE INSURANCE			
					HIC #_____		COMPANY_____		POLICY #_____		
Date of Service	Provider	Unassigned & Assigned	Amount Billed	Maximum Limit	Amount Approved	Amount Paid	Balance Due	Date Submitted	Amount Paid	Date Paid	Amount Not Covered

NORTH DAKOTA Senior Health Insurance Counseling (SHIC)

INSURANCE INFORMATION FORM

Client Name:	DOB:	SSN:
Client Address:		Home Phone #:

Insurance Company (1st - Primary) Address (City, State, Zip):		Insurance Company (2nd - Secondary) Address (City, State, Zip):	
Telephone #: Fax Phone #:		Telephone #: Fax Phone #:	
Contact Person:	Date: Time:	Contact Person:	Date: Time:
POLICYHOLDER: POLICY #:		POLICYHOLDER: POLICY #:	
COMMENTS:		COMMENTS:	

SECTION C

MEDICARE INTRODUCTION

Background C-1

Medicare Administration C-2

Eligibility C-3

Enrollment C-4

Medicare Card C-7

Sample Medicare Cards C-8

Payment System C-8

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Advance Beneficiary Notice C-13

Exercise C-39

Background

Medicare is a federal health insurance program for people 65 or older and some disabled people under 65 and those with End Stage Renal Disease (ESRD) who have had a transplant or receive dialysis on a regular basis. In addition, the Benefits Improvement and Protection Act (BIPA) 2000 extends Medicare coverage to persons with Lou Gehrig's Disease (amytrophic lateral sclerosis-ALS) immediately upon diagnosis because of the short life expectancy.

1. Medicare was created as part of Lyndon B. Johnson's Great Society Program. Medicare was the first large federal health insurance program established by the United States government.

2. Medicare was enacted into law in 1965 as Title XVIII of the Social Security Act and became effective July 1, 1966.

3. Medicare covers beneficiaries in 50 states, Washington, DC, and U.S. territories and possessions: U.S. Virgin Islands, Northern Marianas Islands, American Samoa, Puerto Rico, and Guam.

4. Medicare has two parts: hospital insurance (Part A) and medical insurance (Part B):

   a. **Hospital insurance (Part A)** helps pay for inpatient hospital care, limited skilled nursing facility care, home health care following a hospital stay, and hospice care.

   b. **Medical insurance (Part B)** helps pay for physician services, outpatient services, durable medical equipment, and home health care when there has been no hospital stay.

NOTE: There are differences between Part A and Part B in terms of benefits, eligibility, administration, and the appeals process.

5. Medicare was never intended to pay 100 percent of medical bills. Like private health insurance, there are "gaps" in Medicare where the beneficiary must pay a portion of medical expenses. Beneficiaries share the cost by paying:

a. **Deductible:** A flat dollar amount the beneficiary is responsible for before Medicare coverage will begin. [Example: Part A hospital deductible for first 60 days; Part B annual $100 deductible.]

b. **Coinsurance or copayment:** A percentage or dollar amount of covered expenses which the beneficiary is required to pay. [Example: Part A daily coinsurance for days 61-90; Part B coinsurance of 20%.]

6. Medicare only pays for services determined to be **reasonable and necessary** for the diagnosis or treatment of a specific illness or injury. Decisions about what is reasonable and necessary are always based on professional medical advice.

Medicare Adminis-tration

Medicare benefits are administered by the **Centers for Medicare & Medicaid Services (CMS)**, an agency of the U.S. Department of Health and Human Services. Medicare is ultimately controlled by the U.S. Congress.

1. CMS contracts with insurance companies to handle Medicare claims. A company which handles Part A claims is called a **fiscal intermediary**. A company which handles Part B claims is called a **carrier**.

2. In North Dakota, Blue Cross Blue Shield of North Dakota (Noridian) handles most Part A and Part B claims.

Noridian Medicare
4305 13th Avenue SW
Fargo, ND 58103-3373
1-800-247-2267
www.noridianmedicare.com

a. Exceptions include:

Durable Medical Equipment (DME) claims are handled on a regional basis. Our region is served by:

CIGNA Medicare
P.O. Box 690
Nashville, TN 37202
1-800-633-4227
CignaMedicare.com

Home health care claims and hospice are processed by:

Government Benefit Administrators
Medicare Part A
1201 Zenith Drive, Suite 100
Sioux City, IA 51103-5217
(712) 293-5800

Railroad Retiree Medicare Part A claims are processed by:

Noridian Medicare (see page C-2)

Part B claims are processed by:

Palmetto Government Benefits
Administrators GBA
P.O. Box 10066
Augusta, GA 30999-0001
1-800-833-4455

3. Medicare **eligibility and enrollment** are handled by a separate federal agency, the Social Security Administration.

Eligibility

American citizens are eligible for Medicare if:

1. They are **65 years or older** and eligible under their own work record (for information about work record/covered quarters, see page N-14) or that of their spouse for Social Security, railroad, or civil service retirement plans.

2. They have **end stage renal disease** and are receiving dialysis on a regular basis or have received a kidney transplant due to kidney failure.

3. They are any age and eligible for **disability** benefits under Social Security, railroad or civil service retirement plans.

   a. Under Social Security and Railroad Retirement plans, the individual must have been receiving Social Security disability benefits for at least 24 months.

   b. Those diagnosed with Lou Gehrig's disease (ALS-Amyotrophic Lateral Sclerosis) will receive Medicare benefits the first month Social Security disability benefits are received.

   c. Under civil service retirement the individual must have been disabled for 29 or more months.

4. A person 65 or older who is not eligible for Social Security benefits may **purchase Medicare** coverage if that person is:

   a. An American citizen; or

   b . An alien lawfully admitted for permanent residence who has resided in this country five consecutive years before applying for Medicare.

Enrollment

An individual can sign up for Medicare Part A at any time after age 65 with retroactive coverage up to one year. Enrollment in Part B can happen automatically or during three different types of enrollment periods: initial, general, and special.

1. Individuals receiving Social Security benefits prior to age 65 should be **automatically** enrolled. Coverage begins the first day of their birth month if they are 65 years old or the first day of the 25th month if they are disabled.

   a. These individuals receive a Medicare card in the mail from Social Security three months before their 65th birthday notifying them of their enrollment in Medicare Part A and Part B. If they do not want Part B, they must return the form appropriately marked and they will be enrolled for Part A only.

b. If no card is received, a person should contact the nearest Social Security Administration office (see list on page N-7) **prior** to their 65th birthday.

2. The **initial enrollment period** applies to individuals just turning 65 who have not been receiving Social Security benefits.

   a. The seven-month initial enrollment period begins three months prior to the individual's birth month and ends three months following the individual's birth month.

Initial Enrollment

Month 1	Month 2	Month 3	Birth Month	Month 5	Month 6	Month 7

   b. The month of enrollment determines when Medicare coverage becomes effective:

      (1) Individuals who enroll during the three months prior to their birth month are covered beginning on the first day of their birth month.

      (2) An individual enrolling during his/her birth month will be covered beginning on the first day of the following month.

      (3) If the individual enrolls during the month following his/her birth month, coverage begins two months later.

      (4) If the individual enrolls during the second or third months after his/her birth month, coverage begins three months later.

3. The **general enrollment period** is an annual enrollment opportunity for anyone who did not sign up for Part B during the initial enrollment period. General enrollment runs from January 1 through March 31 each year.

General Enrollment

January	February	March	Coverage Begins July 1

a. For people who enroll during general enrollment, coverage begins on July 1 of that year.

b. People who wait until the general enrollment period to sign up for Part B are charged a 10 percent premium surcharge for each 12-month period they delay in enrolling (e.g., if they delay 5 years, the surcharge is 50 percent).

4. The **special enrollment period** applies to those who continue to work past age 65 **and** are covered under an employer group health plan. It also applies to retired individuals who are covered under a working spouse's employer group health plan (EGHP). These individuals must notify Social Security of their intent to remain covered by the EGHP. These individuals may enroll at anytime after age 65 but they **must** enroll no later than eight months after the month of their retirement or of the person who is working. They also have the option of enrolling anytime during the year while they are still working if they decide they want Medicare coverage or their EGHP is discontinued. If an individual enrolls in the first month of retirement, coverage begins that month. If any individual enrolls in any other month, coverage begins the month following.

Special Enrollment

Retire Month	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8

a. Individuals who are eligible for special enrollment are **not** penalized with a 10 percent surcharge **provided** they enroll no later than eight months after the month of retirement.

b. To qualify for special enrollment, at least one spouse must be **working and** have coverage provided by an **employer group plan**.

Medicare Card

Social Security issues each **beneficiary** a Medicare card (see page C-8 for sample).

1. The card shows which part(s) of Medicare the beneficiary has, as well as his/her name and health insurance (Medicare) number, and the effective date of coverage.

2. The number on the card is the Social Security number of the beneficiary, his/her spouse or parent, depending on which work record the individual has become eligible under.

3. The number will be **followed** by a letter designation if eligibility occurs through Social Security retirement. The number will be **preceded** by a letter designation if eligibility occurs through railroad or civil service retirement.

4. If a person loses his/her card or has questions regarding Medicare enrollment, they should contact their local Social Security office (list - page N-7) or use the website to request a replacement card online:

   a. North Dakota toll-free Social Security: 1-800-453-7255.

   b. National toll-free Social Security: 1-800-772-1231.

   c. www.socialsecurity.gov

SAMPLE MEDICARE CARDS

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO | EFFECTIVE DATE

HOSPITAL	**(PART A)**	**07-01-1986**
MEDICAL	**(PART B)**	**07-01-1986**

SIGN HERE →

Pictured here is the redesigned card that Medicare has been issuing since 1990. The "old" card, which does not say "Medicare" in the banner at the top, is still valid.

Health Insurance

RAILROAD RETIREMENT BOARD

NAME OF BENEFICIARY

CLAIM NUMBER

SEX

IS ENTITLED TO

EFFECTIVE DATE

SIGN HERE

Railroad Retirement Insurance Card

Payment System

Medicare has established standardized payment systems for services it will cover.

1. Since September 1, 1990, both Part A and Part B **providers are required by law** to file all Medicare claims for their patients.

2. Medicare pays for most inpatient hospital (Part A) care, home health care, and skilled nursing facility care under the **Prospective Payment System** (PPS). The facilities are paid a set rate based on payment categories called **"diagnosis related groups"** (DRGs).

   a. The amount the facility is paid depends on the individual's diagnosis. (Also see pages D-15 or N-23-24 - "Important Message From Medicare".)

   b. In some cases the Medicare payment may be more than the facility's costs; more often the payments will be less than the facility's costs.

   c. **Hospitals, home health agencies, ambulance companies, and skilled nursing facilities must "accept assignment".** They must accept the Medicare fee schedule as payment in full–they may not pass on the difference to the beneficiary.

   d. The beneficiary will owe only the deductible and/or coinsurance on Medicare-covered services.

   e. In case of extra long stays or very high costs associated with particularly complex cases (known as "outliers"), Medicare can make an extra payment to the hospital.

3. Payments for Medicare Part B services are based on a national fee schedule and whether or not the Part B provider is a Medicare participating provider (accepts assignment).

   a. The fee schedule assigns a dollar value to each service based on work practice costs and malpractice insurance costs. It is the basis for the Medicare-approved amount for Medicare-covered services and may vary from region to region around the country.

   b. **Participating providers** accept the Medicare approved amount from the fee schedule as payment in full. The beneficiary owes only the deductible and coinsurance on Medicare-covered services (also

referred to as "accepting assignment"). (More on this topic beginning on page E-17.)

c. **Nonparticipating providers** may charge beyond the fee scale within limits. The beneficiary may owe up to 15 percent more than the Medicare approved amount, in addition to the deductible and coinsurance. (More on this topic can be found beginning on page E-18.)

d. The Balanced Budget Act of 1997 allows for private contracts between physicians and Medicare beneficiaries for Medicare covered services (more on page E-20).

Advance Beneficiary Notice

Under limited circumstances, a beneficiary cannot be required to pay for services even if Medicare denies the claim.

1. Waiver of liability occurs when Medicare has **denied coverage** of a Medicare covered service and the beneficiary **did not know and did not have reason to know** that Medicare would deny coverage.

2. In order for the beneficiary to know that services would be denied, the provider must inform the beneficiary **prior to performing the service** that denial is expected and why.

3. If the beneficiary did not sign an Advance Beneficiary Notice (ABN) **specific to the service or procedure** and Medicare denies the claim, he/she may not be required to pay the provider. In some cases the beneficiary may be liable for applicable deductibles and coinsurance.

4. An ABN does not apply to services **not covered** by Medicare or to ambulance claims in most cases. In these circumstances, the provider does not have to notify the beneficiary of expected denial.

5. If neither the beneficiary nor the provider could have been expected to know that expenses incurred were excluded from coverage, Medicare will cover the cost.

6. Under both Part A and Part B, waiver of liability may apply to services denied as not medically reasonable or necessary. See samples of Advance Beneficiary Notice forms beginning on page C-13.

Secondary Payer

When more than one payer may be liable for a claim, benefits must be coordinated to prevent duplicate payment of claims. In the following circumstances, Medicare pays **after** the other payer's liability has been exhausted.

1. Items or services covered by a governmental agency or program (e.g., workers compensation and VA).

2. Items or services covered under an employer's group plan when the plan is the primary payer (e.g., the working aged, working people with permanent kidney failure, and certain disabled people). Three months prior to turning 65 an Initial Enrollment Questionnaire (IEQ) is sent to all Medicare eligible beneficiaries. The questionnaire is a means for establishing when Medicare is the secondary payer if a beneficiary or spouse are employed and covered by an employer group health plan. Questions may be asked when treatment is needed to determine what is primary.

3. Items or services covered under liability or no-fault insurance (e.g., homeowners and auto).

Medicare Patient Rights

Medicare beneficiaries have certain guaranteed rights for their protection. One is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services, including the right to appeal. Beneficiaries in the Original Medicare Plan (most North Dakotans are on Original Medicare) are protected from unexpected bills. A doctor or supplier must give notice if there is a possibility Medicare may not pay for a service. If, after the notice is given and the service is still desired, the beneficiary will be asked to sign an Advance Beneficiary Notice (see page C-13).

In addition to the above, there are other guaranteed rights to:

- Information
- Emergency services
- See doctors, specialists (including women's health specialists), and to go to Medicare-certified hospitals
- Participate in treatment decisions
- Know your treatment choices
- Culturally competent services, e.g., getting materials that are translated into a language the beneficiary understands
- File complaints
- Nondiscrimination
- Privacy of personal information
- Privacy of health information

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date **Signature of patient or person acting on patient's behalf**

NOTE: **Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these laboratory tests.**
I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision.
If Medicare does pay, you will refund to me any payments I made to you that are due to me.
If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.
I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these laboratory tests.**
I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.
I will notify my doctor who ordered these laboratory tests that I did not receive them.

_____ _____
Date **Signature of patient or person acting on patient's behalf**

NOTE: **Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-L (June 2002)

HOME HEALTH ADVANCE BENEFICIARY NOTICE

We, _____, your home health agency, expect Medicare probably will not pay for: _____
_____,
because: _____
_____
_____.

This is our opinion. Your doctor has ordered these services for you. We suggest you talk to your doctor, your family, and us about your need for these services. You can get these services if you think you need them. Unless you have other insurance, you may have to pay for these services yourself. We estimate all of these services will cost about $_____.
You can telephone us at: (____)_____. TTY/TDD: (____)_____.
Your "other insurance" is:_____.

IMPORTANT: Ask us to explain the services you may receive under each of your options below.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **Option A. YES.** I want to receive these home health services and get an official Medicare decision about coverage. Please submit a claim, with any evidence supporting my need for these services, to Medicare for its official decision and bill my other insurance, if any. I might have to pay for these services while Medicare is making its decision. If Medicare or another insurer does decide to pay and I have made any payments, I will be refunded any amounts that I am due. I agree to be fully and personally responsible for payment of any amount for which Medicare and my other insurance will not pay.

I understand that I can appeal if Medicare decides not to pay. Medicare will send me notice of its official decision not to pay that explains its decision in my case. That notice will explain how I can appeal Medicare's decision not to pay. If I do not hear from Medicare about its official coverage decision within 90 days, I can telephone Medicare at: (_____)_____. TTY/TDD: (_____)_____.

Option B. YES. I want to receive these home health services. Do NOT submit a claim to Medicare. I agree to be fully and personally responsible for payment of any amount for which my other insurance will not pay. I realize I cannot appeal to Medicare.

Check one box.

Option B.1. ☐ Please submit a claim to my other insurance, but not to Medicare.

Option B.2. ☐ Do not submit a claim either to Medicare or to my other insurance.

☐ **Option C. NO.** I have decided not to receive these home health services for which you expect that Medicare will not pay. I realize I cannot appeal your opinion that Medicare won't pay.

_____ _____
Date Signature of the patient or person acting on the patient's behalf

Please read and sign this form. Return it to us at our address at the top of this notice.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0781. Form No. CMS-R-296 (June 2002)

SKILLED NURSING FACILITY'S NAME & ADDRESS
TELEPHONE NO. AND TTY/TDD NO.

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice:_____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance you may have. Your other insurance is:_____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at: Address:_____ _____ or at: Telephone: _____TTY/TDD:_____.
- If you receive these items or services, we will submit your claim for them to Medicare.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **DATE & SIGN** THIS NOTICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them.

Patient's Name:_____ **Medicare # (HICN):**_____

_____ _____
Date **Signature of the patient or of the authorized representative**

Form No. CMS-10055

Hospital Letterhead

Hospital ABN 1.

_____ Date of Notice	
_____ Name of Patient	_____ Admission Date
_____ Address	_____ Health Insurance Claim (HIC) Number
_____ City, State, Zip Code	_____ Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: *(Insert the name of the addressee.)*

The purpose of this notice is to inform you that we find that your admission for *(specify services or condition)* is not covered under Medicare because *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be safely furnished in another setting)* This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to *(be admitted to/remain in)* the hospital, you will be financially responsible for _____.1/

This notice, however, is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*, and to make that determination.

- **If you disagree with our conclusion:** *(Select as appropriate)*

  Preadmission:
  Request **immediately**, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

  Admission:
  Request **immediately**, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- **If you do not wish an immediate review:**

  You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.

- **Results of the QIO Review:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on (*specify date*). 1/

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-A.

1/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."
For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)
For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

Hospital Letterhead

Hospital ABN 2.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be furnished safely in another setting)*. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on *(specify date)*.1/ If you leave on *(specify date)*1/, you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require. However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*, and to make that determination.

- **If you disagree with our conclusion:**

  Request immediately, **by noon of the first working day** after receipt of this notice, an **immediate review by telephone, or in writing**. You may make this request through us or directly to the QIO at the address listed below.

  The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).

- **If you do not request review by noon of the first working day after receipt of this notice:**

  You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.

- **QIO Review Results:**

  The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

  IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  IF THE QIO AGREES WITH THE HOSPITAL:

  You are responsible for payment for all services beginning on *(specify date)*1/ unless you have requested an immediate review.

  If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____

(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-B.

1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.
For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

Hospital Letterhead

Hospital ABN 3.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered acute care day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be furnished safely in another setting)*. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on *(specify date)*.1/ If you leave the hospital on *(specify date)*, you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion:**

Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on *(specify date)*.1/

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-C.

1/ Insert: the date following the day of receipt of the hospital notice.

Hospital Letterhead

Hospital ABN 4.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered acute care day)*, you no longer need an acute level of care. You will begin to receive the type of hospital services that are furnished in a skilled nursing facility (SNF) beginning *(specify date of first SNF swing-bed day)*. This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period).

However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion and want an immediate review:**

Request ***immediately***, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us, or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-D.

Hospital Letterhead

Hospital ABN 5.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of the QIO)* has concurred with our decision that beginning *(specify date of first noncovered day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be safely furnished in another setting)*. You will also receive a notice from *(name of QIO)* confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning *(specify date)*.1/

- **If you disagree with this decision:**

  You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

  You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

  The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

  IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning *(specify date)*.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-E.

1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice. For specialty hospital and PPS-exempt units, insert: the date specified by the QIO. The beneficiary's liability begins on the day following the date of receipt of the notice.

Hospital Letterhead

Hospital ABN 6.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of QIO)* has concurred with our decision that beginning *(specify date of noncovered acute care day)* further *(specify services to be furnished or condition to be treated) (specify is/are)* medically unnecessary or could be safely furnished in another setting. You will also receive a notice from *(name of QIO)* confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on *(specify date)*.1/ You should discuss other arrangements with your attending physician for any further health care you may require.

- **If you disagree with this decision and want an expedited reconsideration:**

  You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

  You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning *(specify date)*.1/ If you leave the hospital on *(specify date)*1/, you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-F.

_____
1/ Insert: The date of the day following receipt of the QIO and hospital notification.

Hospital Letterhead

Hospital ABN 7.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of QIO)* has concurred with our decision that beginning *(specify date of first noncovered acute care day)* you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning *(specify date of first SNF swing-bed day)*. This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- **If you disagree with this decision and want an expedited reconsideration:**

  You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us, or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

  You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

  The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

  IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-G.

Hospital Letterhead

Hospital ABN 8.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and have determined that further hospitalization paid under the Medicare program is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

We have advised your attending physician of the denial of further skilled nursing care. Upon receipt of this notice, the items and services which you receive will no longer be covered under the Medicare program. The care that you need now is not skilled nursing care, and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on *(specify date)*.1/ You should discuss other arrangements with your attending physician for any further health care you may require.

This notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion and want an immediate review:**

  Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

  You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on *(specify date).*1/

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at _____ *Time* _____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-H.

1/ Insert: the date of the day following receipt of the hospital notice.

Hospital Letterhead

Hospital ABN 9.

_____
Date of Notice

_____
Name of Patient

_____
Address

_____
City, State, Zip Code

_____
Admission Date

_____
Health Insurance Claim (HIC) Number

_____
Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

The purpose of this notice is to inform you that we find that your admission for *(specify service or condition)* is not covered under Medicare because the services to be performed *(specify are not considered skilled care or constitute custodial care)*. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss other arrangements with your attending physician for any further health care you may require. If you decide to *(be admitted to/remain in)* the hospital, you will be financially responsible for 1/.

This notice, however, is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion and want an immediate review:** *(Select as appropriate)*

Preadmission:
Request **immediately**, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, a review of the facts in your case. You may make this request through us, or directly to the QIO by telephone or in writing to the address listed below.

Admission:
Request **immediately**, or at any point during your hospital stay, an immediate review of the facts in your case. You may make this request through us, or directly to the QIO by telephone or in writing at the address listed below.

- **If you do not wish an immediate review:**

You may still request a review within 30 calendar days from the date of receipt of this notice to the address specified below.

- **Results of the QIO Review:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration and appeal rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on *(specify date)*.1/ If you leave the hospital on *(specify date)*1/, you will not be liable for costs for care, except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from
_____ *Name of Hospital* _____
at ____ *Time* ____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-J.

1/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible to receive payment under Part B."
For admission notices issued not later than 3:00 P.M. on the date of admission (i.e., before 3:00 P.M.), insert: "customary charges for all services furnished after receipt of the hospital notice, except for those services for which you are eligible to receive payment under Part B." (If these requirements are not met, insert the liability phrase below.)
For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the days following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

Hospital Letterhead

Hospital ABN 10.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

We have determined that you no longer require an acute (*hospital inpatient*) level of care. Because your doctor disagreed with this decision we are asking the Quality Improvement Organization _____ (*insert name of QIO*) to review your case.

_____ (*insert name of QIO*) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the Quality Improvement Organization.

Sincerely,

_____
(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

October 2003 - Form CMS-10092-K.

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NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost: $**_____).

Medicare will not pay for: _____
_____;

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Form No. CMS-20007 (January 2003)

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MEDICARE OVERVIEW EXERCISE

1. What is Medicare?

_____

_____

_____

2. What year did the Medicare law become effective?

_____

3. Medicare, like Social Security, was never intended to pay 100 percent of a retiree's needs. T _____ F _____

4. Medicare will only pay for services that are _____

_____

5. What agency administers the Medicare program?

_____

6. What is a Medicare "carrier"?

_____

_____

_____

7. If a person is an American citizen and not disabled, what are the eligibility requirements for Medicare?

1. _____

2. _____

8. Describe Medicare's initial enrollment period.

_____

9. The date of one's enrollment has no significance as far as the effective date of coverage. T _____ F _____

10. Describe Medicare's general enrollment period.

_____

_____

_____

11. Are there penalties for late enrollment in Medicare? Yes _____ No _____

12. Describe Medicare's special enrollment period.

_____

_____

_____

13. Who files Medicare claims? Provider _____ Beneficiary _____

SECTION D

MEDICARE PART A HOSPITAL INSURANCE

Medicare Part A Hospital Insurance D-1

Hospital Coverage D-1

Part A Skilled Nursing Facility (SNF) Coverage D-6

Part A Home Health Care D-9

Medicare's Hospice Care D-13

Important Message From Medicare D-15

Appeal Process D-16

Exercise D-19

Medicare Part A Hospital Insurance

Medicare Part A helps pay for services you receive from a **hospital, skilled nursing facility, home health agency or hospice program**.

1. Medicare Part A is premium free for those who have accumulated 40 or more Social Security work credits. One credit is earned for each quarter in which a specific amount of income has been earned. A person who has not worked may draw on the spouse's record. This amount changes annually. (See page N-14 for more information on Social Security work credits.)

2. American citizens and lawfully admitted aliens who are not eligible for premium-free Part A may get Part A coverage by paying a monthly premium. (Figures change annually; listed figures are for 2004).

    a. For those with 30-39 credits, the premium is $189 per month.

    b. For those with fewer than 30 credits, the premium is $343 per month.

Hospital Coverage

Hospital inpatient care is covered if a physician **prescribes** the treatment, the beneficiary requires care that can **only** be received in a hospital, and Medicare **approves** the stay. NOTE: Medicare does not preapprove services.

1. PART A BENEFIT PERIOD/DEDUCTIBLE

    a. Each Medicare Part A benefit period provides 90 days of hospital care, if needed.

        (1) For days 1-60 the beneficiary pays a $912 deductible (2005). Medicare will cover 100 percent of the remaining costs of hospitalization (see note).

        (2) For days 61-90 in a benefit period, Medicare pays all hospital costs **except** for $228 coinsurance per day (2005).

NOTE: Part B charges may also be incurred during hospitalization.

b. There are no limits on the number of benefit periods a Medicare beneficiary can have in a lifetime.

(1) The Part A benefit period is **not** based on a calendar year. A new benefit period begins each time a beneficiary is out of the hospital and has not received skilled care in any other facility for 60 or more consecutive days.

(2) **The deductible will apply to each new benefit period.**

c. In addition to the 90-day renewable benefit period, each Medicare beneficiary has **60 nonrenewable**, **lifetime reserve** days.

(1) Lifetime reserve days can only be used when the Medicare beneficiary has exhausted the 90 hospital days allowed within a benefit period.

(2) The beneficiary pays $456 per day (2005) coinsurance for each lifetime reserve day.

(3) Very few people ever exhaust their 60 lifetime reserve days.

(4) Beneficiaries have the option of whether or not to use reserve days. Use of reserve days is assumed unless the beneficiary notifies the facility in writing that they are not using reserve days.

NOTE: If the daily cost is <u>less than</u> the reserve day coinsurance, the beneficiary may be better off <u>not</u> using reserve days.

NOTE: If the beneficiary is on Medicaid and states that Lifetime Reserve Days are not to be used, Medicaid coverage will also be lost.

2. PART A SERVICES COVERED (also see Medicare and You)

a. Semi-private room and board. (Exception: See Item 3(b)(1)(2))

b. Special care units such as intensive care unit or coronary care unit.

c. General nursing services.

d. Drugs administered to you while you are in the hospital.

e. Lab tests included in the hospital bill.

f. Radiology services included in the hospital bill (i.e., x-rays, radiation therapy).

g. Medical supplies such as casts, splints, and surgical dressings.

h. Operating and recovery room costs.

i. Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services.

j. Use of appliances (i.e., wheelchairs).

k. Blood transfusions after the first three pints.

3. PART A SERVICES **NOT** COVERED

a. Personal convenience items, i.e., television, telephone (if billed separately).

b. Extra charges for private room **unless**

(1) It is medically necessary, or

(2) It is the only type of room available.

c. The first three pints of blood (unless the blood deductible has been satisfied under Part B).

d. Private duty nursing.

4. MISCELLANEOUS HOSPITAL COVERAGE

a. Care in psychiatric hospital

(1) Medicare pays for no more than 190 days of **inpatient** care in a participating psychiatric hospital in a lifetime.

(2) Jamestown State Hospital and the Stadter Center in Grand Forks are Inpatient Psychiatric Facilities. They provide inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

NOTES: Lifetime reserve days do not apply to psychiatric hospitalizations.

Hospitalizations in the psychiatric wing of a medical hospital are treated as regular medical hospitalizations.

Outpatient mental health services are covered under Part B.

b. Care in foreign hospital

(1) Medicare will help pay for care in qualified Mexican or Canadian hospitals in three situations.

(a) The beneficiary is in the United States when an **emergency** occurs and a Canadian or Mexican hospital is **closer** than the nearest United States hospital that can provide emergency services.

(b) The beneficiary lives in the United States and the Canadian or Mexican hospital is **closer** to their home than the nearest United States hospital **regardless of emergency cases**.

(c) The beneficiary is in Canada traveling without unreasonable delay by the most **direct route to or from Alaska** and another state and an **emergency** occurs that requires admission to a Canadian hospital. (Emergencies that occur while one is vacationing in Canada are not covered.)

(2) If a Medicare beneficiary plans to travel outside the United States, he/she should:

(a) Check current Medicare supplement insurance to see if it has foreign travel emergency coverage.

(b) Buy a specialty policy that will cover them for accidents and illnesses outside the United States.

(c) Contact a travel agency for a short-term health insurance policy for foreign travel.

c. Care in a Christian Science Sanitarium

(1) Medicare pays for inpatient care received in a participating Christian Science sanitarium if it is operated or listed by the First Church of Christ, Scientist, in Boston. (There are none in North Dakota.)

Part A Skilled Nursing Facility (SNF) Coverage

Medicare covers nursing home care only under very limited circumstances. Medicare defines skilled nursing care as **care that can only be performed by or under the supervision of licensed nursing personnel**.

1. SNF COVERAGE CRITERIA

   a. A medical professional **certifies** that the beneficiary needs, and actually receives, skilled nursing or skilled rehabilitation services **daily**.

   b. The **skilled services** must be ones that, as a practical matter, can only be provided in a SNF on an **inpatient** basis.

   c. The beneficiary must have been in a hospital at least **three days** in a row (not counting the day of discharge) before being transferred to a participating SNF.

      NOTE: Days spent in an observation bed do not count toward the three days of hospitalization.

   d. The SNF stay is required for a **condition** that was treated in the hospital.

   e. The beneficiary is admitted to the SNF within **30 days** after leaving the hospital.

   f. The facility is a **Medicare-certified** skilled nursing facility.

2. LEVEL OF CARE/PROGRESS

   a. Only skilled nursing home care qualifies for coverage. **Medicare defines skilled care** as a nursing or rehabilitation therapy service that requires the special skills of technical or professional health personnel on a daily basis.

      (1) Skilled nursing services include but are not limited to intravenous feedings; insertion, sterile irrigation, and replacement of

catheters; application of dressings involving prescription medications; and treatment of extensive decubitus ulcers (bed sores) and other widespread skin disorders.

(2) Skilled rehabilitation services include therapeutic exercises or activities; gait evaluation and training; ongoing assessment of rehabilitation needs and potential; and maintenance therapy. Care is considered daily care even if these therapies are offered five days a week.

A service that is ordinarily considered nonskilled may qualify as a skilled service when the patient's overall medical condition requires that skilled nursing or rehabilitation personnel manage or perform the treatment plan, observe progress, or evaluate the need for changes in treatment.

Custodial care (assistance with personal needs by unskilled personnel) and skilled care required only once or twice per week do **not** qualify for coverage.

If the skilled services the beneficiary requires are nursing services, they must be required seven days per week to qualify for Medicare coverage. However, if the beneficiary needs skilled therapy services, and the SNF has them available only five or six days per week, Medicare's criteria that the skilled care be needed daily can still be met.

The Medicare contractor will also require:

(1) That a patient show significant rehabilitation potential and steady progress; or

(2) That skilled services are necessary to prevent further deterioration or preserve current capabilities when full recovery or medical improvement is not possible.

3. BENEFIT PERIOD

a. For the 1st through the 20th day, Medicare pays 100 percent of covered costs **for a qualified stay**.

b. For the 21st through the 100th day, the beneficiary is responsible for a coinsurance of $114 per day (2005).

NOTE: If the beneficiary is discharged before 100 days have elapsed and is readmitted within 30 days of discharge, a new three-day hospitalization period is not required for coverage. The beneficiary is then entitled to coverage for the remaining number of 100 days not used in the previous stay. If the beneficiary is out of the hospital or "skilled" nursing care facility for 60 days or more, a new benefit period begins provided the three-day hospital stay requirement is met.

If the beneficiary is brought to a non-skilled level of care during days 1-30, he/she can be raised back to a skilled level without readmission to a hospital. If the beneficiary qualifies for skilled level of care during days 31-60, a new 3-day hospital stay is required to continue the same benefit period.

4. SKILLED NURSING FACILITY - SERVICES COVERED

a. A semi-private room (two to four beds in a room).

b. All meals including special diets.

c. Regular nursing services.

d. Rehabilitation services such as physical, occupational, and speech therapy.

e. Drugs furnished by the facility during the stay.

f. Medical supplies such as splints and casts.

g. Use of medical appliances such as a wheelchair.

h. Blood, after beneficiary pays for first three pints, unless the beneficiary has previously met the blood deductible under Part B.

5. SERVICES NOT COVERED

a. Physician services (these are covered under Medicare Part B).

b. Personal convenience items such as television, radio, or telephone in the room.

c. Private duty nurses.

d. Any extra charges for a private room, unless it is required for medical reasons.

e. The first three pints of blood received unless satisfied under Part B.

f. Custodial care (see page D-7).

6. SWING BEDS

a. Certain rural hospitals with fewer than 99 beds may enter into "swing bed" agreements. These agreements allow beds to be used as either acute (hospital) or long-term (i.e., skilled nursing) care beds depending on the patient's needs.

b. This allows rural hospitals to have available skilled nursing beds for beneficiaries who do not have access to skilled nursing facilities.

c. Medicare Part A will reimburse a qualified hospital on a formula basis, as if it were a qualified SNF.

d. The beneficiary may be responsible for the SNF coinsurance.

Part A Home Health Care

Beginning January 1, 1998, Part A covers only post institutional home health services for up to 100 visits during a home health spell of illness (see note on page D-10). Those persons with Part A coverage only will be covered for services without regard to the post institutional limitation.

Postinstitutional home health services are services furnished to a Medicare beneficiary:

After an inpatient hospital stay of at least three consecutive days, initiated within 14 days after discharge; or

After a stay in a SNF initiated within 14 days after discharge.

NOTE: **Home health spell of illness** is the period beginning when a patient first receives postinstitutional home health services and ending when the beneficiary has not received inpatient hospital, SNF, or home health services for 60 days.

Home health care is the delivery of **skilled medical** attention to **homebound** patients.

Home health care claims for North Dakota are processed by Government Benefit Administrators in the Regional Home Health Intermediary (RHHI). Beneficiary claims and coverage inquires should be directed to:

Government Benefit Administrators
Medicare Part A
1201 Zenith Drive, Suite 100
Sioux City, IA 51103-5217

1. PART A HOME HEALTH CARE CRITERIA

a. The home health agency must be a **Medicare-participating agency**.

b. The patient must be an eligible Medicare beneficiary who is under a doctor's care. The doctor must **prescribe and authorize** the services which are **reasonable and necessary** to the treatment of the patient's illness or injury.

c. The patient must be **confined** to his/her home.

Criteria 1 - The patient's medical condition restricts his ability to leave the home:

Without the assistance of another individual; or

Without the assistance of a supportive device; or

Because absences from the home are medically contraindicated.

Criteria 2 - The patient leaves the home:

Only to receive medical treatment which cannot be provided in the patient's home; or

Infrequently and for short periods of time for nonmedical purposes and these absences do not indicate the patient has the capacity to obtain health care provided outside rather than inside the home.

NOTE: **To be considered homebound, both Criteria 1 and 2 must be met.**

The Benefits Improvement and Protection Act (BIPA) of 2000 clarifies that beneficiaries may leave home to attend a licensed or certified adult day care without affecting their homebound status. The beneficiary may attend religious services.

d. The patient must need **intermittent skilled care**--nursing care, physical therapy, or speech therapy.

2. HOME HEALTH CARE BENEFIT

Upon referral by a physician, the home health agency will provide a free evaluation to determine if the beneficiary qualifies for coverage.

Medicare pays 100 percent of covered and medically necessary services. There is no deductible.

Claims for payment are submitted by the home health agency and payment is made directly to the agency. The beneficiary receives a "Medicare Summary Notice" showing what was billed; Medicare's portion of the bill; and what, if any, charges the individual must pay.

3. HOME HEALTH COVERED SERVICES

a. Part-time or intermittent skilled nursing care.

(1) Considerations for determining whether a service requires the skills of a nurse include: inherent complexity of the service; condition of the patient; and accepted standards of practice.

b. Therapy (physical, speech, and occupational).

c. Medical social services (i.e., dietary counseling).

d. Part-time or intermittent care (e.g., bathing and changing of dressings).

e. Medical supplies when billed by the home health agency.

f. Durable medical equipment (subject to 20 percent coinsurance).

4. HOME HEALTH AIDE SERVICES (may be covered if received in conjunction with skilled care services)

a. To furnish personal care.

b. To maintain a beneficiary's health.

c. To facilitate treatments.

5. HOME HEALTH SERVICES NOT COVERED

a. Drugs.

b. Homemaker/general household services.

c. "Meals on Wheels" or personal services.

Medicare's Hospice Care

Hospice is a public agency or private organization whose primary role is to provide pain relief and symptom management to terminally ill patients.

1. HOSPICE CARE CRITERIA

a. Doctor certifies the patient is **terminally ill** (diagnosed as having six months or less to live if the illness runs its normal course).

b. Patient **elects** to receive care from hospice instead of regular Medicare benefits for the terminal illness.

c. Care is provided in a home, hospital, or nursing home by a **Medicare certified** hospice.

2. HOSPICE BENEFIT PERIOD

a. Medicare will pay for up to two 90-day periods followed by an unlimited number of 60-day periods.

b. The Medicare hospice benefit only pays for treatment for pain relief and symptom management of a terminal illness.

(1) Regular Medicare will usually help pay for treatment not related to the terminal illness.

(2) When you use regular Medicare benefits, you must pay any required deductibles and coinsurance.

c. Medicare pays 100 percent of most covered hospice services.

d. The beneficiary will have to pay small coinsurance fees for outpatient drugs and inpatient respite care.

3. HOSPICE SERVICES COVERED

a. Doctor and nursing services.

b. Home health aid and homemaker services.

c. Medical supplies and appliances.

d. Physical, occupational, and speech therapy.

e. Drugs (including outpatient drugs for the purpose of pain relief).

(1) The beneficiary is responsible for five percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less.

f. Counseling.

g. Medical social services.

h. Short-term inpatient care (including respite care).

(1) The beneficiary pays a minimal per day portion of the Medicare-allowed rate for inpatient respite care.

(2) Inpatient respite care is limited to no more than five days in a row.

Hospice is a public agency or private organization whose primary role is to provide pain relief and symptom management to terminally ill patients.

IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan ("your Plan") if you are a Plan enrollee.
- You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
- Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.

YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

Date of Discharge: When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.

Your Right to an Immediate Appeal without Financial Risk: When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800-MEDICARE (1-800-633-4227), or TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a noncoverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you. The QIO will decide within one day after it receives the necessary information.

Other Appeal Rights: If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone number of the QIO (or of your Plan).

OMB Approval No. 0938-0692. Form No. CMS-R-193 (January 2003)

How to Appeal Medicare Decisions

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision. The steps you should take to appeal are discussed below.

Appealing Decision Made by Hospitals and Other Providers of Part A Services

Hospitals and other providers issue Notice of Discharge and Medicare Appeal Rights which explain why the provider believes that Medicare will not pay a claim. This is not an official Medicare determination so you may ask the provider to get an official Medicare determination. The official Medicare determination can be appealed. Here are the steps:

Ask your provider to get an official Medicare determination.

To get an official Medicare determination the provider must file a claim on your behalf.

You will receive a Notice of Utilization from Medicare.

The notice is an official Medicare determination.

If you still disagree, you can appeal by following the instructions on the Notice of Utilization.

Appealing Decisions Made by Skilled Nursing Facilities

If a skilled nursing facility (SNF) decides that your care cannot be covered by Medicare, and you disagree, you can insist that the SNF file a claim with its Medicare intermediary. This procedure is known as "**demand billing**".

When the SNF submits the demand bill, the Medicare intermediary will make an official coverage determination. By requiring the SNF to submit a demand bill, you protect your right to appeal the determination made by the Medicare intermediary.

After the initial decision is made on your claim, there are four levels of appeal:

Redetermination: If you disagree with the initial determination, submit a written request to your local Social Security Office within 120 days of the initial determination. If the denial came from the Quality Improvement Organization (QIO) the letter should go to them. Include documents that support your case because a decision will be based on the documents available for review. See page N-7 for contact information.

Administrative Law Judge Hearing: If the reconsideration of your claim is not in your favor, you have the right to request a hearing before an Administrative Law Judge. The amount of the disputed claim must be more than **$100** for intermediary appeals and **$200** for QIO appeals. You must notify Social Security in writing within **60 days** of receiving the reconsideration decision.

Social Security Departmental Appeals Board Review: If the Administrative Law Judge denies your appeal, you may request a review from a Social Security Departmental Review Board. Submit your request within **60 days** of receiving the ALJ ruling. The Departmental Review Board may elect not to review the judge's decision.

U.S. District Court. If the Departmental Review Board declines to review your claim or denies your appeal, and the amount of the claim is greater than **$1,000** for intermediary decisions, or **$2,000** for QIO decisions, you may request a federal court hearing. You should consult an attorney, and your attorney must file a court complaint within **60 days** of the Departmental Review Board decision.

Appealing Pre-admission Decisions Made by a Hospital

If a hospital believes that your proposed stay will not be covered by Medicare, it may decide, without consulting the QIO, not to admit you to the hospital. If this happens, the hospital must give you a determination in writing.

If you or your doctor disagree with the hospital's determination, you can appeal. Here are the steps:

You have **30 days** from the date you received the hospital's determination to ask the QIO to review it. If you want an immediate review of the determination, you must ask, by telephone or in writing, within **three calendar days** of the date your received it.

The QIO will review the hospital's determination and send you its determination.

If the QIO agrees with you and decides Medicare will pay for your stay, the hospital is expected to admit you.

SECTION D
REVIEW EXERCISE

1. Name four areas of Part A coverage.
   a. _____
   b. _____
   c. _____
   d. _____

2. For a person who signs up at age 65 for Medicare and is eligible for Social Security, what is the current Part A premium? _____

3. What is the current Medicare Part A deductible? _____

4. Mr. Smith enters the hospital on January 2 and stays for 20 days. He is discharged to his home and after 40 days must return to the hospital for an additional 10 days. What are his out-of-pocket costs on the hospital bill? _____

5. Which of the following services is not covered under Medicare Part A?
   a. Operating room costs
   b. Intensive care
   c. Drugs while administered
   d. Surgeon charges

6. What is the lifetime maximum benefit for Medicare coverage in a certified psychiatric hospital? _____

7. The 61st - 90th day and 91st - 150th day of inpatient hospital care during a benefit period are renewable. T _____ F _____

8. Under what two circumstances will Medicare pay for a private hospital room?
   a. _____
   b. _____

9. While traveling as a tourist in Canada, Medicare will not pay for any Part A expenses. T _____ F _____

10. If you wish to travel overseas, what should you do about health insurance?
    _____

11. What conditions must be met before Medicare will pay for skilled nursing facility care?

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

12. Medicare pays for all levels of care in a nursing home. T _____ F _____

13. There are many elderly persons that need some amount of custodial care but do not need skilled nursing care. T _____ F _____

14. How many days can Medicare cover during each benefit period in an SNF?

_____

15. What does Medicare pay for the 21st - 100th day in an SNF if the stay is approved? _____

16. What are the requirements for Medicare Home Health coverage?

a. _____

b. _____

c. _____

17. Doctor and nursing services, homemaker services, and short-term respite care services are covered by:

a. Home health care coverage

b. Hospice coverage

c. Skilled nursing facility

18. What are Medicare's requirements for coverage of hospice care?

a. _____

b. _____

c. _____

19. A beneficiary may appeal a hospital's decision to deny continued Medicare coverage for a hospital stay. T _____ F _____

20. The Prospective Payment System (PPS) is the method by which Medicare pays for most inpatient hospital care. T _____ F _____

21. According to federal law, a Medicare beneficiary's discharge date is determined solely by "DRGs" or Medicare payments. T _____ F _____

22. Mr. Williams is a slightly confused 88 year old man who needs a nurse to draw a monthly Digoxin level. He uses the assistance of a walker to ambulate. A neighbor comes by each evening to drive Mr. Williams to a local café. The SN (skilled nurse) feels this may be the only meal Mr. Williams has each day. Is Mr. Williams considered homebound? Yes _____ No _____

23. Mrs. Cruse is an 85 year old lady who needs the nurse to administer her Calcitonin three times a week for treatment of osteoporosis. Mrs. Cruse is unable to self-administer the drug due to severe arthritis in her hands. She requires the assistance of one person to leave home. On Sundays, church members will transport her to church. Would Mrs. Cruse meet the homebound criteria as described by Medicare? Yes _____ No _____

24. A physician orders home health aide visits three times per week. The home health aide provides services such as the preparation of meals, light cleaning, and taking out the trash. The beneficiary lives with an elderly, frail sister who is disabled and who cannot perform these tasks. Would home health aide visits be reasonable and necessary? Yes _____ No _____

SECTION E

MEDICARE PART B
MEDICAL INSURANCE

Medicare Part B Medical Insurance E-1

Physician Services E-2

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Medicare Part B Medical

Medicare Part B medical insurance covers physicians' services, outpatient hospital care, ambulance services, prosthetic devices, medical equipment, and a number of other health services and supplies not covered by Medicare's hospital insurance.

The **Part B beneficiary costs** include a monthly premium, an annual deductible, coinsurance, and excess charges.

1. The monthly premium is $78.20 (2005).

   a. The Part B premium is normally deducted from the Social Security check.

   b. For persons who are enrolled in Part B but do not receive a Social Security check, bills are issued for premiums every three months.

   c. American citizens and lawfully admitted aliens who are not covered by Social Security and are not eligible for premium-free Part A of Medicare, pay the same Part B premium if they choose to purchase Part B.

2. PART B BENEFIT PERIOD/DEDUCTIBLE

   a. The calendar year, January 1-December 31, is the Part B benefit period. It is automatically renewable. A beneficiary is responsible for the first **$100** of Part B approved charges in each **calendar year**.

   b. Payment for services not covered by Medicare and charges in excess of the Medicare approved charges **do not apply** to the deductible.

3. PART B COINSURANCE

   a. **Medicare Part B pays 80 percent** of the charges approved for coverage. (Exceptions for lab and mental illness are discussed on pages E-4 and E-6.)

b. **A beneficiary is responsible for 20 percent** of the Part B approved charges for covered services (after the deductible).

c. A beneficiary must also pay the difference between the actual charge and the Medicare approved charge, up to a specified limit, when the physician or supplier does not accept Part B assignment. These are called **excess charges** (more on excess charges on pages E-18 and E-19).

Physician Services

Part B helps pay for covered services **received from a doctor** in his or her office, in a hospital, in a skilled nursing facility (SNF), in the home, or any other location in the United States or its territories.

1. For Medicare purposes, the term "doctor" includes licensed:

   a. Physicians (i.e., Doctors of Medicine (M.D.) or Osteopaths (D.O.)).

   b. Dental surgeons.*

   c. Chiropractors.*

   d. Optometrists.*

   e. Podiatrists.*

   *** Part B coverage for services by this provider is limited.**

   f. The term "doctor" does not include Christian Science practitioners or naturopaths.

   g. Other "qualified" reimbursable health care professionals include clinical psychologist and social worker, physician assistant, certified nurse-midwife, nurse practitioner, and dietician.

2. PART B COVERED SERVICES OVERVIEW

a. Medical and surgical services including anesthesia.

b. Diagnostic tests and procedures including X-rays.

c. Outpatient hospital services.

NOTE: The Balanced Budget Act (BBA) changed the hospital outpatient coinsurance from up to 50% of the facility's actual charge to 20% over a number of years. The Benefits Improvement and Protection Act (BIPA) 2000 accelerates the phase-down to 40% by 2006 and clarifies that coinsurance for all outpatient services provided during a day may not exceed the Part A deductible which is $912 per benefit period in 2005.

d. Drugs and biologicals administered by professionals.

e. Medical equipment and supplies other than common first-aid needs.

f. Visit to physician for second opinion about recommended surgery for treatment of a Medicare covered medical condition.

(1) Medicare beneficiaries are encouraged to seek a second opinion about recommended nonemergency surgery. If the first two opinions contradict each other, Medicare will help pay for a third opinion.

(2) Medicare pays for a second opinion the same way it pays for other doctor services (i.e., 80 percent of approved amount; you pay 20 percent coinsurance).

g. Laboratory services (e.g., blood tests and urinalysis).

(1) The provider must accept assignment. Part B pays 100 percent of approved charges for covered clinical diagnostic tests (except in rural health clinic labs where deductibles and coinsurance apply).

(2) These payments do not count toward meeting the yearly deductible.

(3) Labs may be independent, hospital outpatient or in a doctor's office, and must be certified.

3. LIMITED COVERED SERVICES

a. **Chiropractic services:** Part B pays for manual manipulation of the spine to correct a subluxation (dislocation). Part B **does not** pay for x-ray services provided by a chiropractor.

b. **Podiatry services:** Part B does not cover routine foot care such as cutting or removal of corns or calluses, trimming nails, other hygiene, and preventive maintenance care unless the beneficiary has a systemic disease which would make the unskilled performance of such procedures hazardous.

(1) Medicare will cover treatment of injuries or diseases of the foot such as hammer toe, bunion deformities, and heel spurs.

4. SERVICES NOT COVERED

a. Routine physical examinations and tests directly related to such examinations (**exceptions** include Pap smears, mammography screenings, and prostate screening tests on a specified schedule, and some examinations provided in federally qualified health centers; see "Other Covered Services" beginning on page E-10).

b. Routine foot care (see limited covered services-Item 3(b) above).

c. Eye or hearing examinations, specifically for prescribing or fitting hearing aids or eyeglasses. Medicare **does cover** the first set of lenses after cataract surgery.

d. Routine immunizations **except** flu, pneumonia, and hepatitis B.

e. Cosmetic surgery unless needed because of accidental injury or to improve the functioning of a malformed part of the body.

f. Dental care **except** for surgery of the jaw or related structures or setting fractures of the jaw or facial bones. Pulling teeth to prepare for radiation may be covered.

g. Services connected with treatment for alcoholism or drug dependency.

h. Acupuncture.

i. Self-administered drugs **except** some immunosuppressive drugs and oral cancer drugs.

Outpatient Services

SERVICES COVERED (PART B)

1. Medical

a. Charges in an emergency room or outpatient clinic.

b. Lab tests and x-rays billed by the hospital.

c. Medical supplies such as splints and casts.

d. Drugs which cannot be self-administered.

e. Blood transfusions furnished to an outpatient beginning with fourth pint.

2. Mental health services are subject to a payment limitation called "outpatient mental health treatment limitation".

a. These services are paid at 50 percent of approved charges after the Part B deductible is met.

b. Outpatient treatment of mental illness can be provided by a physician, a clinical psychologist, or a clinical social worker.

c. Part B will pay for the treatment of a mental, psychoneurotic, or personality disorder for an individual who is not an inpatient.

NOTE: Evaluation for services such as psychiatric testing and evaluation to diagnose the patient's illness are not subject to the limitation.

3. Rehabilitation therapy

a. Doctor must prescribe service, set plan of treatment, and review the plan on a regular basis.

b. The therapy services can be received in one of three ways:

(1) Services can be received in a physician's office.

(2) Services can be received directly from an independently practicing Medicare-certified physical or occupational therapist in his/her office or in the home if such treatment is prescribed by a physician.

(3) Services can be received as an outpatient of a hospital, SNF, home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare.

Ambulance

Part B covers ambulance service in approved vehicles when transportation in another vehicle would endanger the beneficiary's health.

1. Medicare will pay for transportation from home to the **nearest** hospital or skilled nursing facility or from the hospital or skilled nursing facility to home. This coverage is limited to specific situations:

   - The service is considered reasonable and necessary, OR
   - Other means of transportation cannot be used due to medical conditions.

   a. Emergency ambulance transportation to the nearest facility will be considered by Medicare when the patient:

      - Suffers from severe pain, bleeding, or shock.
      - Is unconscious.
      - Must be restrained to prevent injury to self or another person.
      - Has suffered an accident, injury, stroke, or heart attack.
      - Must remain immobile because of a bone fracture or the possibility a bone fracture has not yet been set.
      - Requires oxygen or other medical treatment during transport.

   b. Medicare covers ambulance transportation in non-emergencies but only when the patient is bed confined. Medicare considers one to be bed confined if the patient is:

      - Unable to get out of bed without assistance.
      - Unable to walk.
      - Unable to sit in a chair or wheelchair.

2. Medicare will not pay for ambulance use as routine transportation.

3. Air ambulance may be covered if:

   a. The medical condition endangers the life or seriously imperils the health.

   b. Immediate medical treatment is required for survival or to avoid severe health damage.

   c. Land transportation is not available or would endanger life or health.

NOTES: For Medicare to pay, a doctor or other medical professional must certify that a non-emergency ambulance transport is medically necessary. Certification can occur either before or after transport.

Medicare occasionally denies air ambulance claims--always appeal.

Ambulance claims are generally processed where the patient originated.

Durable Medical Equipment

Part B covers durable medical equipment (DME) and supplies under two general conditions: a physician must **order or prescribe** the equipment prior to purchase or rental of the equipment, and the equipment must be **medically necessary**. Most DME claims are processed by:

CIGNA DMERC Medicare
P.O. Box 690
Nashville, TN 37202
1-800-633-4227
cignamedicare.com

1. Durable medical equipment must be for use in the patient's home, be able to withstand repeated use, and primarily serve a medical purpose. It includes:

   a. Oxygen equipment.

b. Wheelchairs.

c. Certain other medically necessary equipment.

2. Covered supplies/equipment include:

a. Prosthetic devices, which are devices needed to substitute for an internal organ (i.e., heart pacemakers), corrective lenses needed after cataract surgery, and colostomy and ileostomy bags and certain related ostomy supplies.

b. Artificial limbs and eyes; and arm, leg, back and neck braces.

c. Supplies ordered by a physician in connection with medical treatment immediately after surgery for a specified time, e.g., surgical dressings. Splints and casts are processed by the local Medicare contractor.

d. Re-agent (test) strips, lancets, and other supplies necessary for the proper functioning of a blood glucose monitor (diabetics). The amount of lancets and test strips covered every month depends on whether or not you use insulin to control diabetes.

- Medicare will also pay for a glucose monitor machine.

- Medicare covers one pair per year of therapeutic shoes and shoe inserts for people with severe diabetic foot disease.

- Prior to July 1, 1998, Medicare paid for glucose monitor and other materials for insulin dependent diabetics only.

- After July 1, 1998, these items are also covered for non-insulin dependent diabetics.

- Self-management training is also covered for diabetics under certain circumstances.

NOTE: Non-insulin dependent beneficiaries should have their physician submit a letter stating when they received the glucose monitor. Otherwise, the carrier will deny claims for the test strips.

3. Noncovered items include:

   b. Exercise equipment.

   c. Bathtub rails, shower chairs, hi risers.

   d. Hearing aids, dentures.

   e. Adult diapers or underpads.

   f. Support hose, elastic stockings.

   g. Telephone alert/communication aids.

   h. Most prescription drugs.

   i. Routine first aid supplies.

4. Documentation for DME supplies may include:

   a. Written order.

   b. Written order prior to delivery.

   c. Certificate of Medical Necessity required for some items.

      (1) CMS form with four sections. Sections B and D should be completed by physician or staff; Sections A and C should be completed by supplier.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

FORM APPROVED
OMB NO. 0938-0875

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03A

MOTORIZED WHEELCHAIRS

SECTION A — Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

(_ _ _) _ _ _ - _ _ _ _ HICN _____

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(_ _ _) _ _ _ - _ _ _ _ NSC # _____

PLACE OF SERVICE _____

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODES:

_____
_____
_____
_____

PT DOB ___/___/___; Sex ___ (M/F); HT._____(in.); WT._____(lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER

(_ _ _)_ _ _-_ _ _ _ UPIN # _____

SECTION B — Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C — Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on Form CMS-854.

☐ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON Form CMS-854**

SECTION D — Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS-843 (05/97)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0875. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, write to: CMS, 7500 Security Blvd., N2-14-26, Baltimore, Maryland 21244-1850.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(_ _ _) _ _ _ - _ _ _ _ HICN _____	(_ _ _) _ _ _ - _ _ _ _ NSC # _____

PLACE OF SERVICE _____	HCPCS CODE	PT DOB ___/___/___; Sex ___ (M/F); HT._____(in.); WT._____(lbs.)
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (_ _ _) _ _ _ - _ _ _ _ UPIN # _____

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____% c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "**X**".
a) _____ mm Hg b) _____% c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.	
Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM CMS-484 (11/99)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0534. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, write to: CMS, 7500 Security Blvd., N2-14-26, Baltimore, Maryland 21244-1850.

Home Health

The Balanced Budget Act (BBA) 97 transferred from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or SNF.

1. Beginning January 1, 1998, Part A will cover only postinstitutional home health services for up to 100 visits during a home health spell of illness (see note on page D-10):

   a. **Except** for those persons with Part A coverage only, who will be covered for services without regard to the postinstitutional limitation.

2. Part B covers home health services not associated with a hospital or nursing home stay or if you exhaust the 100 visits under Part A.

   a. The increase in the Part B premium attributable to transferred expenditures will be phased in over a period of seven years between 1998 and 2004.

Other Covered Part B Services

1. Portable diagnostic x-ray services

   a. Part B covers these services when received at home if a physician orders them.

   b. Equipment must be provided by a Medicare-certified supplier.

2. Mammography screenings

   a. Part B covers a **yearly** mammography screening for Medicare beneficiaries over 40. The Part B deductible is waived. 20% copayment must be paid by beneficiary.

   b. The screening must be taken on assignment.

   c. Under some circumstances, diagnostic or screening mammograms may be covered more frequently.

NOTE: If coverage for a diagnostic mammogram is denied, it may be worthwhile to appeal.

3. Pap smears

   a. The Part B deductible is waived. 20% copayment must be paid by beneficiary. Tests may be conducted every two years.

   b. Medicare will cover more frequent screenings if a physician considers a woman to be at high risk of developing cervical cancer.

4. Colorectal screening

   a. For Medicare beneficiaries over 50 an annual screening fecal-occult blood test is covered.

   b. For Medicare beneficiaries over 50, one screening flexible sigmoidoscopy every four years is covered or every two years if at high risk.

   c. Screening colonoscopy every four years or every two years for high risk individuals. Effective July 1, 2001, the screening is available for those of average risk for colon cancer.

NOTE: A physician may substitute a barium enema for the sigmoidoscopy or colonoscopy.

5. Bone mass measurements

   a. Medicare will cover bone mass measurement for certain high risk Medicare beneficiaries.

6. Vaccines

   a. Flu.

   b. Pneumonia.

   c. Hepatitis B.

7. Effective January 1, 2000, Medicare covers a yearly prostate cancer screening test for male Medicare beneficiaries over age 50. Coverage includes the following:

   Screening digital rectal examination - This test is a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate.

   Screening Prostate Specific Antigen blood test (known as PSA) - This test detects the marker for adenocarcinoma of the prostate.

Participating Physician/ Supplier Program

Each year CMS invites providers to enter "Participating Physician/ Supplier Agreements." Providers who sign these agreements accept assignment on all claims for Medicare patients for that year. Providers can "sign up" as participating providers in December for the following year.

Carriers publish a Medicare Participating Provider/Supplier (MEDPARD) directory listing all participating providers in the area. To access the MEDPARD Directory: www.noridianmedicare.com.

Assigned Claims vs. Unassigned

Approved Charge (also called "reasonable" or "allowable" charge).

1. The **approved charge** is the amount set by the Medicare fee schedule for covered services and supplies and upon which Part B payment is based.

2. The **Assigned Claim**. Definition: A physician or supplier accepts "assignment" for a claim when he or she **accepts Medicare's approved charge** as full payment. Medicare generally pays 80 percent of the approved charge and the beneficiary is responsible for 20 percent.

NOTE: The "approved charge" is Medicare's 80 percent plus the beneficiary's 20 percent.

   a. With assignment, the beneficiary pays only 20 percent coinsurance (after the $110 deductible).

b. The beneficiary is not responsible for any excess charges (i.e., the difference between the Part B approved charge and the provider's actual charge).

c. Providers must accept assignment for anyone on Medical Assistance (Medicaid).

EXAMPLE OF ASSIGNED CLAIM FOR PART B SERVICES:

Mr. Anderson's bill for surgery totaled	$1,500
Part B Approved	$1,000

The surgeon accepted assignment, so Mr. Anderson is not responsible for paying any excess charges.

If Mr. Anderson has met his $110 deductible:

- Medicare pays 80% of the approved charge ($1,000 x 80%)	$ 800
- Mr. Anderson pays the 20% coinsurance ($1,000 x 20%)	$ 200

NOTE: When providers accept assignment, they receive no payment for the excess over the allowable charge.

d. Providers choose whether or not to accept assignment. **A nonparticipating provider may accept assignment on a case-by-case basis**. In most cases, the beneficiary must ask the provider about accepting assignment. (See section on Participating Physician/ Supplier Agreements, page E-17.)

3. Claims process for assigned claims

a. The provider must file the claim with Medicare.

b. The carrier sends a Medicare Summary Notice (MSN) to the beneficiary detailing the charges from the assigned claim.

c. The carrier pays the provider directly (i.e., sends a check to the provider for 80 percent of the approved charge). Beneficiary handles no checks from Medicare under an assigned claim.

4. The **Unassigned Claim**. Definition: If a physician or supplier **does not** agree to accept Medicare's approved charge as the total charge, it is called an unassigned claim.

   a. The beneficiary may be responsible for a portion of the **excess charge** over the approved charge (in addition to the 20 percent coinsurance payment).

   b. Beginning in 1991, providers are limited to allowable caps except in states which have implemented mandatory assignment or stricter balance billing limits. The current limit on charges is 15 percent of the Medicare approved charge.

      NOTE: Limiting charges do not apply to all Part B providers.

   c. The physician or supplier may ask the patient to pay at time of service.

5. Claims process for unassigned claims

   a. The provider must file the claim with Medicare.

   b. Carrier sends a Medicare Summary Notice (MSN) to beneficiary detailing the various charges.

   c. Attached to the MSN is a check to the beneficiary for 80 percent of the approved charge.

   d. The beneficiary should cash the check or endorse it to the provider. **The beneficiary must pay the provider the amount due directly** (the Medicare amount, the coinsurance, and the excess charge, if any).

   e. Since 1993, MSNs have included a line item listing the 15 percent limiting charge or excess charge.

f. A nonparticipating provider must give the beneficiary an "estimate" before elective surgery over $500.

g. If the physician does **not** provide this information in writing before the procedure, he/she cannot charge for any amount above the Medicare approved charge.

EXAMPLE OF UNASSIGNED CLAIM FOR PART B SERVICES:

Mr. Anderson's bill for surgery totaled	$1,500
Part B Approved	$1,000

The surgeon did not accept assignment, so Mr. Anderson is responsible for paying the excess up to 115% of the approved amount.

If Mr. Anderson has met his $110 deductible:

Medicare pays 80% of the approved charge ($1,000 x 80%)	$ 800
Mr. Anderson pays the 20% coinsurance ($1,000 x 20%)	$ 200
Plus the excess up to 115% of the approved charge ($1,000 x 115%)	$ 150

NOTE: Approved charges usually are less than actual charges.

Private Contracting

Section 4507 of the Balanced Budget Act of 1997 allows doctors to enter into private contracts to provide Medicare-covered services to Medicare beneficiaries.

1. **Medicare law has always allowed beneficiaries to go to the doctor of their choice.** Nothing in Section 4507 limits choice of doctors for beneficiaries in traditional fee-for-service Medicare.

2. **Section 4507 only applies to Medicare-covered services.** It does not prohibit beneficiaries from seeing their doctor for non-Medicare covered services such as annual exams and eye exams. Doctors can set their own rates for non-covered services even if they receive Medicare payments for providing Medicare-covered services to the same or other beneficiaries.

3. **Section 4507 adds a third payment possibility for Medicare-covered services. Section 4507 allows doctors to opt out of Medicare and to enter into private contracts with beneficiaries to provide Medicare-covered services at a rate set by the doctor.** A doctor may accept Medicare assignment, submit a bill directly to Medicare, and be paid at the Medicare payment rate. The beneficiary only pays the copayment and deductible. If the doctor does not accept assignment, the doctor may also bill the beneficiary for up to 115 percent of the Medicare approved rate.

4. **Section 4507 comes with a price for the doctors.** In exchange for being able to set their own rate schedules, doctors must agree to give up Medicare payment for all patients for two years after entering into the private fee arrangement. Doctors must also inform beneficiaries that they will not be reimbursed by Medicare or a Medicare supplemental policy for the services they will receive, even though the services are covered by Medicare.

5. **The two-year opt out provision and the notice requirement were designed to protect Medicare beneficiaries.** Beneficiaries will know when they enter into a private contract and before they receive the health services that they will be personally responsible for the full amount of the bill. Doctors will not be able to pick and choose which beneficiaries to treat based on financial or health status.

Medicare Record Keeping

It is important that beneficiaries keep detailed records of Medicare transactions. This assists the beneficiary in determining the amount of benefits due and in understanding Medicare payment decisions. Use the Claim Information Sheet on page E-30 or some other payment record form.

1. What to record:

   a. When service was received and from whom:

      (1) Date.

      (2) Provider.

      (3) Service(s) plus all itemized bills.

   b. When claim was submitted:

      (1) The date the claim was mailed, the date and charges for each service listed in the claim, and the provider of these services.

      (2) The beneficiary should keep a copy of claim form, a copy of itemized bills, and the original MSN.

NOTE: If your Medicare supplement company or another provider requests the original MSN, be sure to keep a copy.

   c. When service was paid for and to whom:

      (1) Date and amount paid.

      (2) What service(s) the payment covered.

      (3) Receipt for payment listing the above.

   d. When correspondence was sent:

      (1) Copies of written communications and a record of telephone calls showing date, time, person, and agency of each telephone inquiry.

Appealing Decisions Made by Carriers on Part B Claims

After the initial determination on your Part B claim which will be explained on the Medicare Summary Notice (MSN), there are five levels of appeal available as explained below:

1. **Carrier Redetermination:** If you disagree with the carrier's initial determination, request the carrier review your case within **120 days** of receiving the Medicare Summary Notice that contained the carrier determination you are appealing.

2. **Carrier Hearing:** If you want to appeal the decision of the carrier review, you may request a hearing. The hearing must be requested within **60 days** of receiving notice of the results of the review. The carrier hearing officer will review the evidence and may conduct a telephone or personal interview before making a decision if requested.

3. **Administrative Law Judge Hearing:** If you disagree with the decision made during a carrier hearing and the amount of your disputed claim is at least **$100,** you may request a hearing before an Administrative Law Judge. To file for a hearing, you must send written notice to CMS or your local Social Security office within **60 days** of receiving the carrier hearing officer's decision.

4. **Social Security Departmental Appeals Board Review:** If you disagree with the Administrative Law Judge's decision, you may request a review before the Social Security Departmental Review Board within **60 days** of receiving notice of the Administrative Law Judge's decision. The Departmental Review Board may elect not to review your case.

5. **U.S. District Court:** If you disagree with the decision made by the Departmental Review Board and there is at least **$1,000** in dispute, you can request a federal court hearing.

Fraud and Abuse Issues

Fraud and abuse occur in part because of the inherent complexities of the Medicare program, unscrupulous providers, and limited funding to develop and implement program safeguards to deter abusive providers. In recent years, efforts to combat fraud and abuse have become much more consistent and high profile.

A. Definitions

1. Fraud is an intentional deception or misrepresentation of services to obtain some benefit of monetary value. The most frequent kind of fraud arises from a false statement or misrepresentation related to entitlement or payment under the Medicare program.

2. Abuse is incidents or practices of providers inconsistent with accepted sound medical, business, or fiscal practices. The practices may directly or indirectly result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented the facts to obtain payment.

B. Common Medicare Rip-offs

1. Billing for services or supplies that were not received.

2. Offers of free testing or screening in exchange for your Medicare number.

3. A provider performs services that exceed what is needed.

4. A provider offers or accepts referral fees from another provider in exchange for the referral.

5. A provider misrepresents the services billed to Medicare.

6. Charges to a client/patient for filling out claim forms.

7. Excessive charges for services or supplies.

8. Claims for services that are not medically necessary.

9. Offers to waive the 20 percent coinsurance or deductible.

C. Detecting Fraud and Abuse: Things to Look For

1. Home Health Agencies/Hospice: Look for

Beneficiaries who are not homebound* (see definition below) but who are receiving home health services.

Beneficiaries who are not terminally ill but are enrolled in hospice.

Residents of board and care homes or assisted living facilities receiving home health care from the same HHA.

Always review MSNs to insure services billed coincide with service provided.

***Homebound** does not necessarily mean bedridden. The condition of a homebound patient is such that there exists a normal inability to leave home and leaving home requires a considerable and taxing effort. A patient may still be considered homebound if absences from home are infrequent or for periods of relatively short duration, primarily for the purpose of receiving medical treatment. Occasional absences for nonmedical purposes would still allow a person to be considered homebound as long as they are on an infrequent basis or of relatively short duration

and do not indicate that the patient has the capacity to obtain the health care provided outside, rather than in the home.

Generally, a beneficiary will be considered to be homebound if a condition due to illness or injury restricts ability to leave the home except with the aid of supportive devices (crutches, canes, wheelchair, walker), the use of special transportation, or the assistance of another person or if the person's condition means leaving the home is medically contraindicated.

2. Clinical Labs: Look for

"Free" services billed to Medicare or other insurers.

Dates of service (for lab claims should generally be within 7-10 days of a practitioner visit; lab services must be ordered by a physician or other licensed practitioner).

Always review MSNs to insure services billed coincide with services provided.

3. Hospitals:

Review MSNs to insure services billed coincide with services provided.

Review itemized statements from the hospital to assure that the patient has not been charged for items not provided.

NOTE: Remember that for inpatient services, the itemized charges usually do not have an impact on the Medicare reimbursement.

4. Ambulance: Look for

Ambulatory patients requiring regular medical services (e.g., dialysis) being transported by ambulance.

Always review MSNs to insure services billed coincide with services provided.

5. Physicians/Practitioners: Look for

Statements by beneficiaries that no physician was present at any time during the service or that s/he has never seen the physician/ practitioner.

Payments (in cash or in kind) in return for providing the Medicare number or for visiting a clinic or office.

Compare the physician statement provided at the time of service to the services shown on the MSN.

Always review MSNs to insure services billed coincide with services provided.

6. Mental Health Services: Look for

Group therapy sessions where recreational or diversional activities are being provided.

The presence of mental health providers with patients who are non-communicative or cannot benefit from psychotherapy (e.g., patients in coma or in late stages of Alzheimer's).

Always review MSNs to insure services billed coincide with services provided.

7. Nursing Facilities: Look for

Kits marked for individual patients used for other patients or held in extremely large supply in storage areas.

Therapies being provided to groups of patients (may be billed to Medicare as if provided individually).

Therapies being provided to patients who cannot benefit from the services.

Every patient having the same medical equipment.

Patient file access provided to persons who are not actual practitioners for specific patients.

8. Durable Medical Equipment Suppliers: In facilities look for DME items that have been provided to all or most residents.

Does it appear that the consumer requires the supplies or equipment received?

Did the supplier waive co-pays and deductibles in the absence of financial need?

Watch for fraudulent attempts to obtain Medicare numbers.

Be wary of "free" services billed to Medicare or other insurers.

Always review MSNs to insure services billed coincide with services provided.

D. Reporting Fraud and Abuse

1. Part A: Contact the intermediary (Noridian Administrative Services) at 1-800-663-4227.

2. Part B: Contact the carrier (Noridian Administrative Services) at 1-800-663-4227.

OR

3. For either Part A or Part B: Write Medicare Fraud, 4305 13th Ave SW, Fargo, ND 58103-3309.

4. Home Health/Hospice: Contact the intermediary (Government Benefit Administrators) or write Medicare Part A Correspondence, 1201 Zenith Drive, Suite 100, Sioux City, IA 51103-5217.

5. DME: Contact CIGNA Medicare at 1-800-663-4227 or write CIGNA Medicare, P.O. Box 690, Nashville, TN 37202.

6. Call the National Toll-Free Number: 1-800-HHS-TIPS (447-8477).

In most cases, the customer service representative will ask you to describe the situation or circumstances. They will want to be sure there is not a billing error or other simple mistake or misunderstanding. In some cases, the customer service representative will have a list of specific questions to ask you. This is the type of situation where you will need to have a signed authorization form (if you are not with the beneficiary at the time of the call) and the contractor may require a physical copy of it.

You and/or the client can remain anonymous. Recognize that if you do, the contractor may be limited in how far it can pursue the investigation and you will not receive information as to the outcome. Providing your name does not mean it will be given to the individual or entity being investigated.

CLAIM INFORMATION SHEET

Name _____

Year _____

					MEDICARE			PRIVATE INSURANCE			
					HIC #		COMPANY	POLICY #			
Date of Service	Provider	Unassigned & Assigned	Amount Billed	Maximum Limit	Amount Approved	Amount Paid	Balance Due	Date Submitted	Amount Paid	Date Paid	Amount Not Covered

MEDICARE PART B
MEDICAL INSURANCE EXERCISE

1. What type of medical services does Medicare Part B cover?
   _____

2. What is the monthly premium for Medicare Part B? _____

3. Medicare Part B coverage for eligible beneficiaries is optional.
   T _____ F _____

4. The Part B calendar year deductible is _____

5. Medicare pays 80 percent of approved charges on most covered Part B services.
   T _____ F _____

6. Explain Medicare's "approved charges".
   _____

7. A "nonparticipating physician" may accept assignment on a case-by-case basis.
   T _____ F _____

8. When providers accept assignment, they accept Medicare's payment of 80 percent of the approved charge as payment in full for the service.
   T _____ F _____

9. Medicare will pay for x-rays furnished by a chiropractor. T _____ F _____

10. Dental care services covered by Medicare are very limited.
    T _____ F _____

11. List several doctor's services covered under Part B.
    _____
    _____

12. Who is responsible for the portion of a physician's bill that is not paid by Medicare? _____
    _____

13. Medicare will pay for prescription drugs purchased at the local pharmacy.
    T _____ F _____

14. Medicare pays 80 percent of the approved charges for treatment of outpatient mental illness. T _____ F _____

15. If you are unhappy with your looks, Medicare will be happy to pay for a facelift.
T _____ F _____

16. What are two conditions that must be met for Part B to cover durable medical equipment and supplies?
a. _____
b. _____

17. What are some of the preventive health care services covered by Medicare?
_____
_____
_____
_____

18. Physicians or practitioners can have private contracts with some Medicare beneficiaries but not others. T _____ F _____

19. The three payment options available to physicians as of January 1, 1998, are accepting assignment, not accepting assignment, and _____.

SECTION F

MEDICARE PART D
PRESCRIPTION DRUG BENEFIT

Medicare Modernization Act of 2003

Senior Health Insurance Counseling
North Dakota Insurance Department

1

In this module we will discuss the Medicare Prescription Drug, Improvement and Modernization Act of 2003. We will focus on the areas of the new law that are of greatest interest to people with Medicare. We often refer to the new law as the "Medicare Modernization Act of 2003" or "MMA."

Medicare Today

- 43 million beneficiaries (2006) growing to over 62 million in 2020
- North Dakota, 103,000 (2005)
- $284 billion in expenditures growing to $898 billion in 2020
- Need to adapt to new health care delivery models
- Need for supplemental coverage

2

Since 1965, Medicare has been a tremendously important program for millions of enrollees and their families. Today, Medicare serves approximately 43 million beneficiaries, and those numbers will continue to grow with the influx of the baby boom population in the near future. It is predicted that by 2020, Medicare will be serving over 62 million beneficiaries.

Medicare also has made an enormous impact on the overall health care system. In FY 2004, we estimate that the program will spend $284 billion, making Medicare the third largest program after Social Security and Medicaid. By 2020, we expect Medicare spending to reach $898 billion.

However, it is important to remember that even though the program has been a big help in paying for health care costs, there are still some gaps in coverage, and changes to reflect modern medicine have not always kept pace. People with Medicare have had to rely on supplemental insurance ("Medigap") or a Medicare Advantage plan (formerly known as Medicare + Choice), such as an HMO, to receive additional benefits like prescription drugs and to reduce their out-of-pocket costs.

Medicare Today

Current commercial market:

- 70% in PPOs or POS plans
- 25% in HMOs
- 5% in fee-for-service

Medicare market:

- 90% in fee-for-service
- 10% in Medicare Advantage plans

3

The trend in the private health insurance market has been to provide network plans that can give enrollees a choice of providers. Since 2002, the vast majority of the commercial market has been enrolled in Preferred Provider Organizations (PPOs) or Point-of-Service (POS) plans, with only 5 percent of the private commercial market being covered in conventional fee-for-service plans.

As you can see, the Medicare market today is very different from the private sector commercial market with 90 percent in fee-for-service and a small percentage receiving services in a Medicare Advantage plan delivery system. An objective of the new legislation is to bring the same type of choices to persons with Medicare as those currently available in the "under-65" market.

Medicare Modernization Act of 2003 (MMA)

2004	2005	2006
• Drug discount card • Medicare + Choice now Medicare Advantage	• Drug discount card • New preventive services • Part B deductible increases to $110	• Prescription drug plans • Two new Medigap policies • Part B deductible increases with premium

A number of provisions will be implemented as a result of the passage of MMA. Not all provisions will be implemented immediately.

Major provisions being implemented in 2004 include:

- Medicare-approved drug discount cards, available in 2004 and 2005
- Medicare Advantage, the new name for Medicare + Choice plans
- A moratorium on planned limits on coverage for some outpatient therapy

Provisions being implemented in 2005 include:

- Coverage for some new preventive services
- An increase in the Part B deductible from $100 to $110

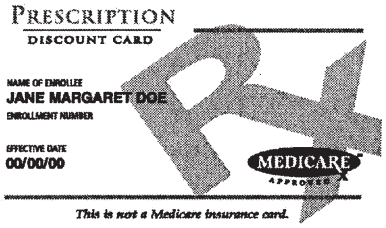
Additional provisions, to be implemented in 2006, include:

- Medicare prescription drug plans, the new Medicare drug benefit
- Changes in Medigap
- Additional changes to the Part B deductible

Drug Discount Cards

Medicare-Approved Drug Discount Cards

- Became effective June 2004
- Temporary, ends December 31
- Voluntary
- "Medicare-Approved" seal



The cost of paying for prescription drugs has been increasing every year, especially for people with Medicare. Medicare pays for some drugs, like oral cancer therapy drugs and drugs provided to inpatients in hospitals, but Medicare doesn't cover most outpatient prescription drugs.

Medicare-approved drug discount cards are an interim way to help people with Medicare save on prescriptions until the Medicare prescription drug benefit is available in January 2006. To help lower the costs of prescription drugs, Medicare contracts with private companies to offer voluntary discount cards. A Medicare-approved drug discount card offers certain drugs at a negotiated price for card members. Savings are estimated to be 15-30 percent or more on many drugs.

These cards are offered temporarily. People could enroll as early as May 2004 and could begin using the cards starting in June. The discount cards will continue through December 2005 when Medicare will offer comprehensive prescription drug coverage.

There is only one group of people who can't enroll in a Medicare-approved drug discount card—people whose outpatient drugs are covered by Medicaid.

It is important to remember this is not a Medicare benefit and these are not Medicare cards. They are cards offered by companies that have been approved to use the "Medicare-Approved" seal, kind of like Medicare's "Good Housekeeping Seal" of approval.

Drug Discount Cards

$600 Credit

- Provides immediate relief to certain people with lower incomes
  - No more than $12,919 (2005) for a single person
  - No more than $17,320 (2005) for a married couple
  - No asset limits
  - QMBs, SLMBs, and QIs deemed income-eligible
- Coinsurance based on income (5% or 10%)
- Cannot use for over-the-counter drugs

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One of the unique features of this card is the immediate relief it provides for the individuals who need it the most. In the law this is called "transitional assistance," but the term we use is "$600 credit."

People with Medicare with an income no more than 135 percent of the federal poverty level (FPL) may qualify for a $600 credit, unless they have other drug coverage from such programs as Medicaid, TRICARE for Life, FEHBP, or an employer group health plan. The income limits for 2005 are $12,919 for a single person and $17,320 for a married couple. These limits are based on the FPL amounts, which are updated in February each year. There are no asset limits, and it doesn't matter how high your drug costs are. Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying (QIs) are deemed to meet the income qualifications for the $600 credit.

Even though you may be eligible for the $600 credit to use toward the cost of your prescriptions, you will have a coinsurance payment. The coinsurance will be 5 or 10 percent depending on your income. Specifically, if your annual income is no more than 100 percent of the FPL ($9,570 for an individual and $12,830 for a married couple), you will be responsible for a 5 percent coinsurance. If your annual income is between 100 and 135 percent of the FPL (between $9,570 and $12,919 for an individual or between $12,830 and $17,320 for a married couple), you will be responsible for a 10 percent coinsurance. The card gives a discount only for the individual who applied for the card. Therefore, married couples need to apply for cards separately.

If you qualify for the $600 credit, you can use the credit for prescription drugs whether they are on the company's preferred list or not, but you cannot use the $600 credit on over-the-counter drugs.

Drug Discount Cards

Applying for $600 Credit

- Choose a discount card
- Apply to the company offering your card
- Apply by
  - March 31 to get $600 credit
  - June 30 to get $450 credit
  - September 30 to get $300 credit
  - October 1 and later, get $150 credit

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If you wish to apply for the $600 credit, you will have to fill out an application and sign it certifying your annual income and family size. The application must go to the card company of your choice. CMS will then verify the self-certified information for the card company and determine your eligibility.

You can apply for the $600 credit any time during 2004. No matter when you enroll in 2004, if you are found to be eligible you will receive the full $600 for 2004 and the full $600 for 2005, with no need to reapply.

However, if you wait until 2005 to apply, the amount of the credit you receive will depend on when you enroll. Even though you may be found eligible for the credit, you will lose $150 for every quarter you wait to enroll. So if you enroll in July of 2005, for example, you will receive a credit of $300.

Any unused amounts at the end of 2004 may be carried over for use in 2005 as long as you stay with the same card company, or if you change during the allowable times. Any unused portions left at the end of 2005 can be carried over for use until May 2006, (as we transition to the prescription drug benefit) or when you enroll in Medicare prescription drug plans, whichever comes first.

Prescription Drug Plans

Medicare Prescription Drug Plans

- Available January 2006
- Offered through private prescription drug plans (PDPs)
- Can be offered by Medicare Advantage plans

8

In January 2006, all 41 million people with Medicare will have the option to enroll in a plan that covers prescription drugs.

CMS will contract with private prescription drug plans (PDPs) to negotiate discounted prices on behalf of their enrollees. Insurance companies and other appropriate organizations can bid to serve as prescription drug plans. You can also receive drug benefits through your Medicare Advantage plan if you are enrolled in one.

Prescription Drug Plans

Eligibility and Enrollment

- Must be entitled to Part A and/or enrolled in Part B
- Enrollment is voluntary
- Enrollment penalties for persons who wait
  - Exception for those covered under other comparable insurance

9

Anyone entitled to Medicare Part A or enrolled in Part B will be eligible to join a Medicare prescription drug plan.

Enrollment is entirely voluntary. However, if you choose not to join Medicare prescription drug plans at your first opportunity, you may face a late enrollment penalty if you later choose to enroll. This penalty is similar to the penalty currently in place for late enrollment in Medicare Part B. People who have another source of drug coverage—through a former employer, for example—may stay in that plan and not enroll in Medicare prescription drug plans. If your other coverage is **at least as good as Medicare prescription drug plans** (called "creditable coverage"), you can avoid any late enrollment penalties if you later join Medicare prescription drug plans. The penalty is 1 percent of the base premium for each month you do not have creditable coverage. Examples of creditable coverage may include

- Coverage under prescription drug plan or Medicare Advantage prescription drug coverage
- Medicaid
- Group Health Plan (GHP)
- State Pharmaceutical Assistance Program (SPAP)
- VA coverage
- Medigap with prescription drug coverage
- Military coverage including TRICARE

Instructor's Note: To be eligible for the Medicare-approved drug discount card, you must be entitled to or enrolled in Part A and/or enrolled in Part B. This is the same eligibility requirement as for the drug benefit. You must have either Part A or Part B, or both.

Source – Issue Paper: "Eligibility and Enrollment"

Prescription Drug Plans

Eligibility and Enrollment

- Initial enrollment
  - November 15, 2005 - May 15, 2006
- Subsequent years
  - Open enrollment November 15 - December 31
- Will not be enrolled automatically
  - Exception: Medicaid recipients with drug coverage

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Initial open enrollment for Medicare prescription drug plans will begin November 15, 2005 and will run for 6 months until May 15, 2006.

In later years, open enrollment will run from November 15 to December 31 for changes effective the following benefit year. The enrollment periods for drug-only plans and Medicare Advantage plans will run concurrently.

You will not be enrolled in a plan unless you fill out an application and enroll with a plan. One **exception** to this would be if you were receiving outpatient drug coverage through Medicaid, in which case you will be required to enroll in a plan. Medicaid recipients who do not sign up during the required timeframe will be automatically enrolled in a plan.

Source – Issue Paper: "Eligibility and Enrollment"

Prescription Drug Plans

Your Costs in 2006

- Generally about a $37 monthly premium
- $250 deductible
- 25% of drug costs from $250 to $2,250
  - Medicare pays 75%
- 100% of drug costs from $2,250 to $5,100
- After you spend $3,600, Medicare pays approximately 95%

These are annual amounts i.e. must be met each year.

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People with Medicare enrolled in a prescription drug plan will pay a premium estimated to be $37 a month and will be responsible for a $250 deductible each year. Once the deductible has been met, Medicare will pay 75 percent of drug costs up to $2,250 in total expenditures, and you pay the other 25 percent of these costs. You will be responsible for 100 percent of drug costs between $2,250 and $5,100, which constitutes the benefit gap or doughnut hole. Once you have reached $3,600 in out-of-pocket costs, Medicare will pay approximately 95 percent of your drug costs, and you will pay 5 percent, for the rest of that year. This is called catastrophic coverage. **Keep in mind, this is on an annual basis**, so these amounts must be met each year.

Out-of-pocket expenditures include:

- Annual deductible
- Coinsurance and copayment amounts

Costs must be incurred by the beneficiary (or another person such as a family member on behalf of the beneficiary) or under an SPAP, with no reimbursement from insurance, a group health plan, or other third party.

Prescription Drug Plans

Let's look at a case study

- Aaron has a Medicare prescription drug plan and takes three prescription drugs. His Medicare prescription drug plan includes all his drugs in its formulary. Aaron has paid his $37 premium from January through May and has met his $250 deductible. How much in drug costs does he have to incur before reaching the catastrophic limit?

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Aaron will pay his monthly premiums regardless of his drug costs.

He will reach his catastrophic limit after he has paid the following drug costs

- His deductible of $250
- 25 percent of his drug costs from $250 to $2,250 = $500.

  That is: .25X($2,2500$250)=$500

- All (100 percent) of his drug costs between $2,250 and $5100 = $2,850

Once Aaron has incurred a total of $5,100 in drug costs, and paid $3,600 out-of-pocket, he will reach the catastrophic limit and Medicare will pay 95 percent of his additional drug costs in that year.

Aaron's Case Study

- Aaron pays monthly premiums regardless of drug costs.
- He will reach catastrophic limit after paying:
  - His deductible = $250
  - 25% of costs between $250 and $2,250(.25X2000) = $500
  - 100% of drug costs between $2250 and $5100 = $2850
  - TOTAL OUT-OF-POCKET COSTS = $3600
- Once Aaron incurs a total of $5,100 in drug costs ($3,600 out-of-pocket) he reaches the catastrophic limit. Medicare pays **95%** of his *additional* drug costs in that year.

13

The calculations for this slide are based on the following:

•The annual deductible is $250, which has to be paid by Aaron before the drug plan will pay anything.

•Aaron has to pay 25% of the cost of his medications after he has paid the first $250 (the deductible). The maximum amount of this co-payment category is $500. Aaron could pay less than $500 co-payments only if during the year his medication costs altogether are less than $2,250 ($250 + $2,000).

•Aaron has to pay 100% out-of-pocket for medication costs above the $2,250 limit, until reaching the total out-of-pocket cost, the CATASTROPHIC limit, of $3,600.

NOTE! The above figures will change each year! They will rise based the increased cost of medical care!

Low-income Subsidy

- Certain low-income groups are automatically given the subsidy
- Other low-income "applicants" must apply for the subsidy and meet an income and asset test
- Apply through Social Security or Social Services

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The term subsidy is used to describe the assistance that will be given by Medicare to those who qualify for it. The qualifications for the subsidy are: Low-come and low asset levels. These income and asset levels are defined in a later slide. Some low-income persons, those who are Medicaid recipients and also on Medicare (these people are often referred to as dual eligibles) will be automatically enrolled into the subsidy. Other low-income persons, generally those within the income limits but have assets that exceed the Medicaid limits, may be eligible for the subsidy. This latter group will need to apply for the subsidy.

Beginning in June dual eligibles will receive a letter telling them they are automatically enrolled in the subsidy. Other low-income persons will be identified by Social Security. This group will receive a letter from Social Security telling them of the subsidy and encouraging them to apply for the subsidy. The letter will contain a subsidy application and an envelope to return the application to the Social Security processing center.

Prescription Drug Plans

Low-Income Subsidy beginning January 1, 2006

- Group 1
  - Full benefit dual eligibles with incomes below 100% FPL
- Group 2
  - Full benefit dual eligibles and non-dual eligible beneficiaries with incomes of 100%-135% FPL and limited resources ($6,000 per individual and $9,000 married couple)
- Group 3
  - Beneficiaries with incomes of 135%-150% FPL and limited resources ($10,000 individual and $20,000 married couple)

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As we learned for Medicare-approved drug discount cards, there is help for individuals with lower incomes.

But before we go into that topic, it is important to define the term "full benefit dual eligibles." Full benefit dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are also eligible for outpatient prescription drug benefits through Medicaid.

Three groups have been identified for lower-income assistance:

- Group 1are full benefit dual eligibles with incomes below 100 percent of the Federal poverty level (FPL), with no resource limits
- Group 2 are full benefit dual eligibles and non-dual eligible Medicare beneficiaries with incomes between 100 percent and 135 percent of the FPL, with resource limits of $6,000 per individual and $9,000 for a married couple.
- Group 3 are Medicare beneficiaries with incomes between 135 percent and 150 percent of the FPL, with resource limits of $10,000 for an individual and $20,000 for a married couple.
- Now let's look at the assistance for each group.

Prescription Drug Plans

Low-Income Subsidy

	Group 1 (below 100% FPL)	Group 2 (100-135% FPL)	Group 3 (135-150% FPL)
Premium $37.00/month (est.)	$0.00	$0.00	Sliding scale based on income
Deductible $250.00/year	$0.00	$0.00	$50.00
Coinsurance up to $3,600 out of pocket	$1/$3 co-pay	$2/$5 co-pay	15% coinsurance
Catastrophic 5% or $2/$5 co-pays	$0.00	$0.00	$2/$5 co-pay

NOTE: Low-income persons who are institutionalized pay $0

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If you are in Group 1, you are not responsible for the monthly premium or the deductible. You are only responsible for small copayments, $1 for generics and $3 for brand-name drugs. If through paying these nominal copays you reach $3,600 in out-of-pocket costs, you would not be responsible for any other co-pays for the rest of the year.

If you are in Group 2, you are not responsible for the monthly premium or the deductible. You will have a $2 copay for generic drugs and a $5 copay for brand-name drugs. If through paying these nominal copays you reach $3,600 in out-of-pocket costs, you would not be responsible for any other co-pays for the rest of the year.

If you are in Group 3, your premium will be based on a sliding scale depending upon your income. You will be responsible for a reduced deductible of $50 per year, and you will be responsible for 15 percent of the cost of your prescriptions up to the $3,600 out-of-pocket maximum. Once you have reached that maximum, you will have a $2 copay for generic drugs and a $5 copay for brand-name drugs for the rest of the year.

As you can see, there is no benefit gap where these groups would be responsible for 100 percent of the costs.

The next slide has dollar amounts for the 2005 Federal Poverty Level.

Prescription Drug Plans

Federal Poverty Level
2005 Values

	Group 1 (below 100% FPL)	**Group 2** (135% FPL)	**Group 3** (150% FPL)
Single	$9,570/yr $797/mo	$12,919/yr $1077/mo	$14,355/yr $1,196/mo
Couple	$12,830/yr $1,069/mo	$17,320/yr $1,443/mo	$19,245/yr $1,604/mo

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Those in Group 1 are considered to be the 'deemed' persons. They will be automatically enrolled in the subsidy. They will receive a letter in June telling them they are enrolled in it. They must still choose a drug plan beginning November 15, 20005.

Some persons in Group 2 may be automatically enrolled in the subsidy but only if they are also on Medicadi.

Persons in Group 3 will have to apply for the subsidy. This was presented in an earlier slide.

Those in Group 3 will have to apply as they will not be automatically placed into the subsidy category. Group 3 are generally not known by Medicaid.

Remembers there is an asset test, too, that will determine eligibility for the subsidy.

Prescription Drug Plans

Application Process

- For some there will be two steps:
  - Apply for the subsidy beginning in June
  - Enroll in a Part D Prescription Drug Plan beginning November 15
- All others enroll in Part D Prescription Drug plan beginning November 15

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If you are in Group 1, you are not responsible for the monthly premium or the deductible. You are only responsible for small copayments, $1 for generics and $3 for brand-name drugs. If through paying these nominal copays you reach $3,600 in out-of-pocket costs, you would not be responsible for any other co-pays for the rest of the year.

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If you are in Group 3, your premium will be based on a sliding scale depending upon your income. You will be responsible for a reduced deductible of $50 per year, and you will be responsible for 15 percent of the cost of your prescriptions up to the $3,600 out-of-pocket maximum. Once you have reached that maximum, you will have a $2 copay for generic drugs and a $5 copay for brand-name drugs for the rest of the year.

As you can see, there is no benefit gap where these groups would be responsible for 100 percent of the costs.

Other MMA Provisions

Protections for Retirees

- Retirees concerned about losing their EGHP
- New law works to stabilize the erosion
- Employer must qualify for subsidy
- Subsidy will pay 28% of drug costs per beneficiary enrolled in EGHP
  - Of costs between $250 and $5,000

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A major concern of beneficiaries who have retirement plans with prescription drug coverage is that they would lose those benefits with the introduction of a Medicare prescription drug benefit. However, MMA includes a provision to stabilize the erosion of employer group health plans for retirees. It includes **special payments to employer- and union-sponsored plans** to encourage them to retain and enhance coverage they currently offer their retirees. This new program will begin January 1, 2006.

To qualify for the employer-sponsored coverage subsidy, the employer or union must show that its coverage is at least as generous as the new Medicare drug benefit (meaning "actuarially equivalent"). About one-third of Medicare beneficiaries currently have drug coverage through their former employer, and the coverage is typically among the most generous type available. The new federal subsidy will pay the employer or union 28 percent of these beneficiaries' drug costs between $250 and $5,000. This means that employers will be able to receive federal subsidy payments on average of $611, and as high as $1,330, per beneficiary.

As we discussed earlier, if an employer should drop its coverage at a later date, its retirees who are Medicare beneficiaries will be able to enroll in Medicare prescription drug plans without any late enrollment penalty. Check with your company's human resources department to find out if your plan meets the actuarial equivalence requirement.

Source – Issue Paper: "Protecting Retiree Drug Coverage"

New Preventive Services

"Welcome to Medicare" Physical Exam

- Height and weight measurement
- Blood pressure
- Electrocardiogram (EKG)
- Education and counseling
- Referral for other preventive services
- Performed no later than 6 months after Part B coverage first begins

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First, Medicare will help to pay for a "Welcome to Medicare" initial preventive physical examination that consists of measuring height, weight, and blood pressure, and an EKG, with the goal of health promotion and disease detection. It includes education, counseling, and referral with respect to screening and other preventive services that are already covered under Medicare. However, the benefit does not include payment for clinical laboratory tests.

In order to be covered, the initial physical exam must be performed no later than 6 months after the date your coverage first begins under Part B. And it only applies to those whose coverage for Part B begins on or after January 1, 2005.

Services included in the initial preventive physical exam are subject to the Medicare Part B deductible ($110 for 2005) and co-insurance payments (20 percent). Certain lab tests and other preventive services may be available without cost or with only the co-payment requirement. If a person has a Med. Supp. Plan these costs may be covered by that plan.

New Preventive Services

Diabetes Screening

- Effective January 1, 2005
- For persons at risk—risk factors include
  - High blood pressure
  - High cholesterol
  - Overweight
  - Family history of diabetes
  - Over 65 years of age
- Includes fasting plasma glucose test
- Frequency limits apply
- No deductible or coinsurance

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Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is a hormone that is needed to convert sugar, starches and other food into energy needed for daily life. There are about 18.2 million people in the U.S. with diabetes, or 6.3 percent of the population. While 13 million people have been diagnosed with diabetes, about 5.2 million people (nearly one-third) are unaware that they have the disease. In addition, it is estimated that at least 20.1 million Americans have pre-diabetes, in addition to the 18.2 million with diabetes. *Source: www.diabetes.org/about-diabetes.jsp*

Beginning January 1, 2005, Medicare will pay for diabetes screening tests for the purpose of early detection of diabetes for persons at risk for diabetes. The screening includes:

- A fasting plasma glucose test; and
- Other tests that the Secretary may deem appropriate after consulting with appropriate organizations.

Persons are at risk for diabetes if they have any of the following risk factors:

- High blood pressure or high cholesterol
- Obesity
- Previously elevated impaired fasting glucose or previously impaired glucose tolerance
- At least two of the following characteristics: overweight, family history of diabetes, a history of gestational diabetes or delivery of a baby over 9 pounds, or 65 years of age or older.

The frequency of testing will be determined in consultation with the proper organizations, but it will be no more than twice within a 12-month period. You will not be responsible for a deductible or copayment, since these are clinical laboratory tests.

New Preventive Services

Cardiovascular Screening

- Effective January 1, 2005
- Blood tests for early detection of cardiovascular disease
- Cholesterol levels
- Frequency limits apply
- No deductible or coinsurance

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According to the Centers for Disease Control, heart disease and stroke—the principal components of cardiovascular disease—are the first and third leading causes of death and account for over 40 percent of all deaths in the United States. About 950,000 Americans die of cardiovascular disease each year, one death every 33 seconds. *Source: www.cdc.gov/nccdphp/bb_heartdisease/ index.htm and Issue Paper: "New Preventive Benefits")*

Beginning January 1, 2005, Medicare beneficiaries will have coverage for screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease.

The screening will test for the following:

- Cholesterol levels and other lipids or triglyceride levels; and
- Other indications associated with the presence of, or an elevated risk for, cardiovascular disease.

The Secretary will establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood test, up to once every two years.

You do not have to meet the deductible or have any copays for the tests (since Medicare pays 100 percent for clinical laboratory tests), so you will not incur any cost.

Medicare Advantage Plans

Medicare Advantage Plans

- Better benefits and more choices
- Improved access to doctors and care for people with Medicare
- Reduced premiums and copays or improved benefits
- PFFS enrollees will pay more for going to non-contract providers

The MMA provides additional revenues to health plans in 2004 to encourage more plan choices for Medicare beneficiaries. Medicare Advantage organizations can only use these new funds to reduce premiums or copays, enhance benefits, stabilize or widen the network of providers available to people with Medicare, or reserve funds to help offset premium increases or reduce benefits in the future. Plans that didn't renew for 2004 could re-enter the program by March 1, 2004. Plans that had left in previous years had the opportunity to return, and CMS expedited review of their applications.

Another provision allows some private fee-for-service (PFFS) plans to charge enrollees higher copayments when they obtain care from non-contract providers or professionals. Prior to this law, there was no difference in the cost-sharing amount when the beneficiary utilized a non-contract provider.

As a result of these changes, beneficiaries are seeing improved additional benefits offered by their health plans. Premiums and cost-sharing have dropped, benefits have improved, and provider networks are stronger.

Medicare Advantage plans are especially important to lower-income, minority and/or disabled beneficiaries, who rely on them for their health care, to keep costs affordable, and for the benefits that are not available under the Original Medicare plan.

Information on plan changes is available through 1-800-MEDICARE and at www.medicare.gov on the web.

Sources: Issue Papers – "Regional PPOs - A New Option for Medicare Beneficiaries" and "Immediate Improvements for Private Plans: Provisions Effective in 2004 for M+C Plans"

Medicare Advantage Plans

Specialized Plans

- Certain MA plans can limit enrollment to special needs population
  - Institutionalized beneficiaries
  - Dual eligibles
  - Possibly other "special needs" groups
- Design options to best serve these populations

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Certain specialized Medicare Advantage plans can limit enrollment to special populations to focus on ensuring their needs are met as effectively as possible.

Specialized populations might include institutionalized beneficiaries and those on Medicaid. Requirements may be established for other "specials needs" groups, such as those with severe or disabling chronic conditions, e.g., End-Stage Renal Disease (ESRD).

Sources: "Medicare: Today's Issue, February 12, 2004;" "Medicare: Today's Issue, May 11, 2004"

Medicare Advantage Plans

New Plan Options

- New plan choices in 2006
- Most important new option—Regional Preferred Provider Organizations (PPO)
- Region States

MT	WY	ND	SD
NE	MN	IA	

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In 2006 Medicare Advantage plan choices will be expanded to include regional preferred provider organization (PPO) plans. A PPO has a network of doctors and hospitals that contractually agree to provide services at a specified rate, but also allows enrollees to go outside the network for care, usually with some increased cost to the enrollee. PPOs have been a growing form of health insurance and are now the most popular type of coverage in the private market.

CMS will designate between 10 and 50 regions by January 1, 2005, which must include all parts of the country. Unlike the current Medicare Advantage program, which features local plans that serve individual counties and groups of counties, the new regional Medicare Advantage PPOs will serve an entire state or multi-state areas. The goal of these larger regional markets is to bring more plan options to rural areas by grouping them with the urban areas that have traditionally attracted managed care plans under the Medicare + Choice program.

Source: Issue Paper "Regional PPOs - A New Option for Medicare Beneficiaries"

Other MMA Provisions

Changes to Part B Deductible

- $100 since 1991
- Increases to $110 in 2005
- Updated based on Medicare expenditures, 2006 on

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Since 1991, the Part B deductible—the amount beneficiaries must pay each year before Medicare pays for most services—has been $100 per year. Beginning in 2005, the deductible will increase to $110 per year. For 2006 and subsequent years, it will be updated based on the growth rate in Medicare program expenditures.

Other MMA Provisions

Changes to Part B Premium

- Prior to MMA, standard Part B premium
- Beginning 2007 through 2011, premium based on beneficiary income
- No effect if income below $80,000 (single) or $160,000(couple)

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In the past, all Medicare beneficiaries have paid the same Part B premium (subject to the Part B late enrollment penalty) which was based on 25 percent of the cost of Part B per beneficiary. For the first time, the Part B premium will be income-tested. This change will be phased in over a 5-year period beginning in January 2007. More specifically, in January 2007 the premium will increase for individuals whose income exceeds $80,000 ($160,000 for a couple) per year. For higher incomes, the premium will be based on a sliding scale:

- For individual incomes of $80,000 - $100,000 ($160,000 - $200,000 for a married couple) the Part B premium will be based on 35 percent of the cost of Part B per beneficiary;
- For individual incomes of $100,000 - $150,000 ($200,000 - $300,000 for a married couple) the Part B premium will be based on 50 percent of the cost of Part B per beneficiary;
- For individual incomes of $150,000 - $200,000 ($300,000 - $400,000 for a married couple) the Part B premium will be based on 65 percent of the cost of Part B per beneficiary; and
- Those with an individual income exceeding $200,000 ($400,000 for a married couple) the Part B premium will be based on 80 percent of the cost of Part B per beneficiary.

For More Information

- Visit www.medicare.gov
- Call 1-800-MEDICARE
  - 1-800-633-4227
  - TTY 1-877-486-2048
- Call a SHIC counselor
  - 1-800-247-0560 (328-2440 local)
  - TTY 1-800-366-6888
- Visit www.cms.hhs.gov

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There are a number of sources where you can get more information, including:

- Medicare's website for beneficiaries, www.medicare.gov
- The toll-free number for Medicare, 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
- CMS Publication 11062, *Guide to Choosing a Medicare-Approved Drug Discount Card*
- Your SHIP counselor (See *Medicare & You* handbook, CMS Publication 10050 or visit www.medicare.gov for the phone number)
- Medicare's website for partners, www.cms.hhs.gov

Information is available in both English and Spanish.

SECTION G

MEDICARE SUPPLEMENT INSURANCE

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Medicare Premium and Deductible Rates G-16

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Medicare Supplement Insurance Introduction

Medicare was established as a **"major medical"** insurance plan. Deductibles and coinsurance were built in and some costs (e.g., outpatient prescription drugs) were excluded entirely.

Medicare supplement insurance was created to cover costs excluded by Medicare and to coordinate with Medicare. Employer retiree plans, group policies, HMOs, and other managed care plans were encouraged to offer programs and coverages that coordinated with Medicare.

Medicare Advantage plans may also be available as a means of providing Medicare services and filling the gaps in Medicare. Medicare Advantage plans are discussed in Section G.

1. Medicare supplement insurance is:

    a. Also called "Medigap" or "**MedSup**".

    b. **Private insurance**, **NOT** sold by the government.

    c. Defined and regulated by both state and federal governments.

    d. Sold by many companies.

    e. **Standardized**.

    f. Generally not needed by folks who are eligible for Medicaid or Qualified Medicare Beneficiaries (QMB).

2. All Medicare supplement insurance policies coordinate benefits with Medicare. Except for select benefits, **Medicare must recognize the expense as "eligible" before the supplement policy will pay.**

NOTE: Some retirees, including retired federal employees, have many plans from which to choose depending on their type of employment, length of service, and date of retirement. Some plans serve as Medicare supplements while others may actually substitute for Medicare. **It is necessary to investigate each individual situation carefully.**

Medicare Supplement Standard-zation

Until 1992, there were dozens of different Medicare supplement policies. While all policies were required to cover Part A and Part B coinsurance, insurance companies added a variety of other benefits and combined them in many different ways. This made it very difficult to compare policies and prices.

1. In 1992, by order of Congress, the variety of Medicare supplement policies was reduced to 10 identified by the letters **A through J**.

   a. Every state in the country has adopted almost identical rules prescribing the specific benefits of each of the 10 plans.

   b. North Dakota allows all 10 plans to be sold. Any company selling any Medicare supplement policies **must** sell Plan A. They may sell any combination of the other nine plans.

   c. No matter what company you buy from, the benefits under each plan will be the same (see chart on page G-15). As an incentive to buy policies, some companies add "bells and whistles" such as prescription drug discounts. These added items are not part of the benefits and are not regulated or approved by the North Dakota Insurance Department.

   d. Premium prices and service records can vary considerably from company to company.

2. Three states--Minnesota, Massachusetts, and Wisconsin--implemented state standardization. Policies sold in those states may vary from Plans A-J.

3. Folks who bought pre-standard policies (any policy purchased **before** January 1, 1992) are not affected in any way--unless they want to switch their old policy for a standard one. They should not make such a switch without good reason.

(a) Any time a change in policy is considered, clients should be sure they are accepted by the new company before canceling the old one.

(b) Many Medicare supplement companies have converted policyholders to one of the standardized plans.

Medicare Supplement Open Enrollment

Insurance companies often ask health-related questions and based on your answers, decide whether or not to sell you the insurance. The process is called "**underwriting**" and most policies are underwritten.

1. As a protection for Medicare beneficiaries, Medicare supplement policies have an **open enrollment period**. For this open enrollment period, the company **must** accept you for any policy it sells, at its **lowest** price for customers in your age group. If you have had a break of more than 63 days coverage, a company **may impose up to a six-month waiting period** for coverage of pre-existing conditions.

   NOTE: Companies may have different rates for male and female applicants.

   NOTE: In North Dakota, a smoker applying during the open enrollment period will receive non-smoker rates.

2. To qualify for the open enrollment period, you must:

   a. Be at least 65, and

   b. Purchase a Medicare supplement policy **within six months of the Part B effective date** as shown on your Medicare card.

3. For those who work past age 65, are covered by an employer group health plan, and delay joining Part B, the open enrollment period begins when Part B coverage begins.

4. Medicare supplement for under 65

   a. Disabled people can begin receiving Medicare **before** they turn 65 (refer to page C-3). However, in North Dakota they are **not** eligible for Medicare supplement open enrollment until they turn 65.

   b. Companies are not required to sell Medicare supplement policies to persons under 65. CHAND may be an option for those who have been refused insurance (see Section K).

5. In the past, when an insured reached Medicare eligibility (age 65), issuers of comprehensive health coverage typically canceled the comprehensive coverage and offered Medicare supplemental coverage instead, or the insured was responsible for finding supplemental coverage on his/her own.

   a. Since the passage of the Health Insurance Portability and Accountability Act in 1996, insurers are no longer allowed to cancel the comprehensive health coverage of Medicare eligibles.

   b. New requirements raise several concerns:

      (1) Individuals risk losing their six-month open enrollment window for medicare supplement coverage. This may make it impossible for them to purchase a Medicare supplement policy in the future if they are not in good health.

      (2) Comprehensive health coverage is almost always more expensive than a Medicare supplement policy.

      (3) Comprehensive health coverage does not always coordinate with Medicare so consumers end up paying for duplicate coverage.

      You must evaluate your options for supplementing Medicare very carefully when turning age 65.

Minimum Require-ments

Minimum standards for Medicare supplement policies (basic benefits):

1. Plans must pay for either all or none of the Medicare **Part A inpatient deductible** (first 60 days). Plan A pays none of the Part A deductible; all other plans pay it in full.

2. Plans must pay the **daily coinsurance amount for days 61-90** of a hospital stay per benefit period (Part A).

3. Plans must pay the daily **coinsurance amount for the 60 nonrenewable lifetime reserve days** (Part A).

4. Plans must pay **100 percent of covered services up to 365 lifetime days** for stays when Medicare hospital benefit is exhausted.

5. Plans must pay for the **first three pints of blood** under Part A or B.

6. Plans must pay the **20 percent coinsurance amount under Medicare Part B** after a $110 (2005) deductible.

Plans and Premium Comparison

The Insurance Department maintains Internet web pages that contain current lists of Medicare supplement insurance policies approved in North Dakota. The information includes the rating assigned to the company by AM Best as well as the company's telephone number. The address is www.state.nd.us/ndins. Then click on "Consumers". See pages G-17 to G-22 for samples of standard plans.

If Internet access is not available, premium comparisons may be requested by telephone or mail and the results will be mailed.

Consumer Protections

Medicare supplement plans update each year when Medicare deductibles and coinsurance change. This may mean a premium "update" as well! **It is not necessary to purchase a new Medicare supplement policy to accommodate yearly changes.**

1. Medicare supplement policies coordinate with Medicare.

2. All policies must be **guaranteed renewable**. That means the company cannot cancel the policy if you pay your premium in a timely manner.

3. All MedSup plans **must pay claims that occur six months or more after a policy's effective date** regardless of whether the claim arose from a "preexisting condition" (i.e., six months is the maximum preexisting condition waiting period a company may impose). If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to six months–unless prohibited by your state–may be applied to that particular benefit.

4. If an agent or company sells a policy to **replace** a Medicare supplement the consumer already has, **the replacing insurer shall waive any time period applicable to the preexisting condition** waiting period in the new Medicare supplement policy or certificate to the extent such time has expired under the original policy (i.e., if a policy has been in force for six months or more, no additional waiting period may be imposed--even if the waiting period was shorter in first policy).

5. Open enrollment (see page G-3).

6. All policies must clearly disclose the benefits and letter of plan (A-J). Standardized outlines including the 10 plan chart (page G-15) must accompany all solicitation materials. The company's chart will highlight the plans being offered by that company. The outline should also show the premium for each policy the company is selling.

7. All policies must allow the buyer to cancel a policy without penalty during the **30 days** after receiving the policy. The **"free-look"** provision starts from the day the insured receives the policy.

8. Premium comparison information, updated as needed, is available, on the Insurance Department website, www.state.nd.us/ndins, or by calling 1-800-247-0560, for companies selling Medicare supplement insurance in North Dakota.

9. Suspension of MedSup for Medicaid eligibles

   a. Insurance companies must inform a **Medicaid eligible person** that a MedSup policy is not usually necessary.

   b. If a person with a MedSup plan purchased on or after November 1, 1991, becomes eligible for Medicaid, that company must **suspend coverage** (upon written request of the policyholder) and **waive the premiums** during the time the policyholder is eligible for Medicaid, not to exceed a period of 24 months.

   c. If within the 24-month suspension period the person loses Medicaid benefits, the company (upon written request) must **reinstate an equivalent** policy without any new preexisting condition waiting period and at the appropriate premium had no suspension of benefits taken place.

10. Toll-free line for complaints

    a. If you suspect **violations** of MedSup marketing or have a **complaint** about agents or companies which say they represent Medicare, **call the North Dakota Insurance Department at 1-800-247-0560 or CMS at 1-800-633-4227 (1-800-MEDICARE)**.

Other Policy Features

Crossover and claims handling

1. Some companies have **"crossover" contracts** with Medicare. After Medicare pays its share of the bill, Medicare sends the claims **directly** to the supplement insurance company.

   a. If your doctor or supplier accepts Medicare assignment, you may request the supplement

benefits be paid directly to the provider even if there is no crossover contract. The provider must include your Medicare supplement policy number and company on the Medicare claim form. The claim form must be signed by the insured. Medicare will process the claim and send it to the Medicare supplement company for processing.

b. Clinics/doctors (providers) are **not required to file Medicare supplement claims**--some do.

c. Medicare sends a **"Medicare Summary Notice" (MSN)** to individual client for Part B services. If there is no crossover arrangement or the beneficiary has not given Medicare supplement information to the provider and signed the Medicare claim form, the individual must then send a copy of MSN, along with a claim form (if company requires one) to the beneficiary's MedSup company.

c. Payment may go to the person or provider depending on the terms of policy or on arrangements made with the company or provider.

d. **Keep original MSNs or copies.**

NOTE: The Insurance Department has a list of the electronic crossover insurers licensed in North Dakota, or you may call Medicare at 1-800-663-4227 to find out if an insurer is on the list.

2. State regulation

a. All Medicare supplement policies must be filed with and approved by the State Department of Insurance.

b. To make sure policies meet the state's legal requirements, the Department's policy analysts look at:

(1) Forms.

(2) Advertisements and solicitation materials.

(3) Rates (see also Loss Ratios - page G-10).

3. Premiums

a. Medicare supplement premiums are established in different ways:

(1) **Attained age.** This is currently the most common approach for MedSup. The premium is scheduled to increase automatically as you get older. When you purchase the policy, there are increases scheduled for each year or for every few years. There may also be rate increases based on the company's "experience".

(2) **Issue age.** The premium is set when you buy the policy. If you buy at age 65, you will always pay the company's premium for 65 year olds. The premium may increase for reasons other than age (e.g., experience). The initial premium may be higher than with an attained age policy, but over time an issue age policy may be more economical.

(3) **No age or community rating.** Premiums are the same for all customers, regardless of their age.

b. Medicare supplement premiums are likely to increase, if only to reflect changes in Medicare.

c. A company can ask the Insurance Department for permission to increase the rates for all customers at the same time.

(1) The company must be able to show that the increased premiums are required to cover increased expenses.

(2) When the Insurance Department reviews a company's rates, it looks at **loss ratios**--how

much of the money collected in premiums was actually paid in claims.

(3) Individual policies must have a loss ratio of 65 percent--for every dollar the company collects from consumers, 65 cents must be paid in claims. Group policies have to meet a 75 percent loss ratio.

(4) If a company's loss ratio is too low (for example, it pays only 50 cents out of every dollar on claims), the Insurance Department will require the company to issue refunds to all customers.

Medicare Select

Medicare Select was created by Congress in 1992 and initially available in only 15 states, including North Dakota.

In 1995, Congress approved expanding Medicare Select to all 50 states for three years. In 1998, the Secretary of Health and Human Services made Medicare Select a permanent option.

Medicare Select policies require you to use "network providers".

If you go outside the network for non-emergency services, Medicare Select may reduce the benefits or pay nothing.

Medicare Select is typically sold by HMOs, but other insurance companies also offer it.

1. Medicare select benefits: A-J

Although it may be sold by an HMO, the benefits of Medicare Select must generally be identical to one of the 10 standard Medicare supplement plans. In exchange for seeing a "network provider" (a physician who has agreed to be part of this plan), you pay a lower premium.

2. Select complaints

   Medicare Select plans include a grievance procedure, which must be described in the outline of coverage.

3. Medicare select premiums

   Premiums for Medicare Select **should** be lower than for the same plan without Select's network restrictions.

   Buyers must shop carefully and compare premiums to decide whether the premium reduction (if any) is enough to make up for the restrictions on doctors and hospitals they can use.

Replacement and Duplication of Medicare Supplement

Insurance policies do not need to be replaced just because something new is available. Sometimes, however, it does make sense to switch.

1. To protect consumers against frivolous policy switching, state regulations require the insurance agent or company to fill out a **"replacement notice"** (sample page G-23). Both the agent/company and the buyer must sign the form.

2. It is a federal crime for an insurance agent or company to knowingly sell a Medicare-eligible person a second Medicare supplement plan. If you want to improve your Medicare supplement benefits or decrease your premium costs, do not purchase an additional policy; replace the one you have.

   a. Do not drop the old policy until you know you have the new one. That means waiting until you have actually received the new policy before you cancel the old one.

3. Many specialized or "limited benefit plans" duplicate some coverage provided by Medicare and MedSup. These plans and the regulations governing them are discussed in more detail in Section G.

Medicare Supplement Claims Problems

In case of Medicare supplement payment problems (i.e., if payments are not made according to benefits described in the policy), send a written complaint to the company stating:

Nature of procedure/service/supply.

Amount Medicare paid.

Policy provisions or limits.

Why policyholder feels claim should be paid.

Include copy of MSN and policy specific information (claim processing number, policy or contract number).

If you are still not satisfied after the company responds, call the Insurance Department Hotline at 1-800-247-0560 or send a letter and copy of your correspondence with the company to the North Dakota Insurance Department, 600 East Boulevard, Dept. 401, Bismarck, ND 58505-0320.

KEEP ORIGINAL MSNs

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA 97) made a number of changes to Medicare supplement insurance options. Two new Medicare supplement options are described here:

BBA 97 provides for two high deductible Medicare supplement plans. These will offer the benefit package of either Plan F or Plan J, except for the high deductible feature. The high deductible is $1,690 in 2004 and may be increased by the Consumer Price Index in subsequent years. The beneficiary would be responsible for expenses up to this amount. Currently, a few companies in North Dakota offer the high deductible plans.

Additional options and protections, called Medicare Advantage and guaranteed issue provisions may be found in Section G.

Do's and Don'ts in Supple-menting Medicare

DO insist on a simple outline of the policy which describes the benefits offered. Under law, this outline must be given to a beneficiary when he or she applies for health insurance and before paying or when you receive the policy if purchased through the mail. READ IT CAREFULLY.

DO compare the costs and benefits of plans offered by several insurance companies **before** buying any health insurance policy.

DO find out if the providers you use will regularly accept assignment before deciding on a policy. This information will help in comparing the benefits of various plans.

DO be very careful about buying a policy on the basis of its skilled nursing home coverage. No standardized Medicare supplement policies cover the custodial care most older persons receive in nursing homes.

DO read the policy carefully. If for any reason the beneficiary wishes to cancel the policy, he or she should return the policy to the insurance company by registered mail within 30 days of receipt. Within the 30-day free-look period, the company is required to refund all premiums paid for that policy.

DO call the State Insurance Department if an agent has used unfair or dishonest sales practices. Toll-free in North Dakota: 1-800-247-0560.

DO understand how your employer's group plan will supplement Medicare. Be aware that employers are not required to provide--or continue to provide--health coverage for retirees.

DON'T listen to an agent who says the policy pays for everything that Medicare does not pay. No such policy exists.

DON'T believe the agent who says that a policy offers coverage not listed in the outline of coverage.

DON'T listen to the agent who uses pressure or implies you need to act fast or lose the policy.

DON'T buy any policy that pays only daily "indemnity" or "per-day" benefits, or policies that pay only in the event that you

have a specific disease, like cancer, until you have seriously considered a good comprehensive Medicare supplemental policy.

DON'T keep poor policies simply because one has had them a long time.

DON'T buy more than one Medicare supplement policy.

DON'T pay cash for insurance; write a check or money order payable only to the company, **not** the agent.

DON'T buy from unsolicited door-to-door salespersons until at least checking out the agent's credentials by calling the North Dakota Insurance Department Consumer Hotline at 1-800-247-0560.

DON'T buy from an agent who gives the impression that he or she is from a government agency. **No** agents are affiliated with any government agencies. If an agent gives you this impression, contact the State Insurance Department, since it is an illegal practice.

MEDICARE SUPPLEMENT STANDARDIZED PLANS

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	
				Preventive Care						Preventive Care	

*Plans F and J may also be offered with a high deductible option. These high deductible plans offer the same benefits as Plans F and J **after one has paid a calendar year $1,730 (2005 - amounts change each calendar year) deductible**. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1,730. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

MEDICARE PREMIUM AND DEDUCTIBLE RATES

2004 and 2005

	2004	2005*
PART A		
PREMIUM		
MORE THAN 39 QUARTERS OF QUALIFYING EMPLOYMENT	NONE	NONE
30 TO 39 QUARTERS OF QUALIFYING EMPLOYMENT (10% SURCHARGE)	$189.00 (207.90)	$206.00 (226.60)
LESS THAN 30 QUARTERS OF QUALIFYING EMPLOYMENT (10% SURCHARGE)	$343 $377.30	$375 (412.50)
DEDUCTIBLE/CO-INSURANCE		
1 TO 60 DAYS	$876	$912
61 TO 90 DAYS	$219	$228
MORE THAN 90 DAYS	$438	$456
SKILLED NURSING FACILITY 21st TO 100th day	$109.50	$114
PART B		
PREMIUM (10% SURCHARGE)	$66.60 $73.26	$78.20 $86.00
YEARLY DEDUCTIBLE	$100	$110
MEDIGAP PLANS F AND J, HIGH DEDUCTIBLE OPTION DEDUCTIBLE AMOUNT	$1690	$1730

* Effective January 1, 2005

Premium Comparison - Plan C

The following information was filed with the North Dakota Insurance Department which **does not endorse or recommend a particular company or plan.** Because of a number of factors the **annual premiums below are approximate. Factors such as gender, smoker status, and others, may impact the actual premium amount. Price is not the only issue to consider.** Please review all issues in relation to your own needs before purchasing a policy.

Most plans are underwritten. Plans with an asterisk * in front of the premium amount are sold on a guaranteed issue basis. Click on the link for further information.

Age of applicant is 65.
Premiums listed are based on a new applicant, male, non-smoker.

The following companies base their premiums on attained age which means the premium is based on your age and will increase as you get older. Premiums may also increase based on company experience or due to Medicare changes.

Attained Age:

Company Name	Phone No.	Rating	Annual Premium
Bankers Life and Casualty Company	312-396-6000	B++	$1,095
Union Bankers Insurance Company	800-824-3577	B+	*$1,109
State Farm Mutual Automobile Insurance Company	LOCAL	A++	$1,112
Central States Health & Life Company of Omaha	800-442-4029	A-	$1,135
Pennsylvania Life Insurance Company	888-802-9497	B++	$1,194
American Family Mutual Insurance Company	800-374-1111	A	$1,203
Sterling Investors Life Insurance Company	877-604-6606	B	$1,215
Philadelphia American Life Insurance Company	800-552-7879	B+	$1,254

Noridian Mutual Insurance Company (dba Blue Cross Blue Shield of ND)	800-342-4718	NR-5	$1,256
Continental Life Insurance Company of Brentwood Tennessee	615-377-1300	B++	$1,285
Order of United Commercial Travelers of America	800-848-0123	NR-4	$1,291
Central Reserve Life Insurance Company	800-945-8554	B+	$1,331
Continental General Insurance Company	800-545-8905	B+	$1,350
Constitution Life Insurance Company	800-789-6364	B++	$1,375
Conseco Health Insurance Company	877-266-7326	B++	$1,379
Equitable Life and Casualty Insurance Company	800-352-5150	B++	$1,406
Lincoln Heritage Life Insurance Company	800-438-7180	B++	$1,406
Sterling Life Insurance Company	800-688-0010	A-	$1,410
Humana Insurance Company	800-872-7294	A-	$1,490
GE Life and Annuity Assurance Company	800-896-1211	A+	$1,556
United National Life Insurance Company of America	800-207-8050	NR-2	$1,558
State Mutual Insurance Company	800-780-3724	B+	$1,575
United American Insurance Company	972-529-5085	A+	$1,579
United Teacher Associates Insurance Company	512-451-2224	A-	$1,589
Guarantee Trust Life Insurance Company	800-338-7452	B+U	$1,593
Pyramid Life Insurance Company	800-777-1126	B++	$1,851

Oxford Life Insurance Company	608-662-1232	B	$1,998
Standard Life and Accident Insurance Company	800-827-2524	A	$2,068

The following companies base their premiums on issue age which means your premium is based on your age when you purchased the policy. The company will not raise your premium just because you are getting older. Premium may increase based on company experience or due to Medicare changes.

Issue Age:

Company Name	**Phone No.**	**Rating**	**Annual Premium**
Thrivent Financial for Lutherans	800-225-5225	A++	$1,591
United Healthcare Insurance Company	800-523-5800	A+	$1,632
Combined Insurance Company of America	800-544-5531	A	$1,752
Bankers Fidelity Life Insurance Company	404-266-5500	B++	$1,759
Medico Life Insurance Company	800-228-6080	B-	$2,268
Mutual Protective Insurance Company	800-228-6080	B-	$2,268

If you already have a Medicare supplement policy and are considering making a change it is very important that you not cancel your existing coverage until you are certain the new policy is effective.

PREMIUMS AS OF MONDAY, APRIL 04, 2005.

If you have additional questions, please call 1-800-247-0560 or email us at: ndshic@state.nd.us

Brief Description of Plan C
Pick a Different Age
Pick a Different Plan
Return to Medicare Supplement Home Page

BACK TO MAIN PAGE

Premium Comparison - Plan F

The following information was filed with the North Dakota Insurance Department which **does not endorse or recommend a particular company or plan.** Because of a number of factors the **annual premiums below are approximate. Factors such as gender, smoker status, and others, may impact the actual premium amount. Price is not the only issue to consider.** Please review all issues in relation to your own needs before purchasing a policy.

Most plans are underwritten. Plans with an asterisk * in front of the premium amount are sold on a guaranteed issue basis. Click on the link for further information.

Age of applicant is 65.
Premiums listed are based on a new applicant, male, non-smoker.

The following companies base their premiums on attained age which means the premium is based on your age and will increase as you get older. Premiums may also increase based on company experience or due to Medicare changes.

Attained Age:

Company Name	Phone No.	Rating	Annual Premium
Physicians Life Insurance Company	800-228-9100	A	$1,082
Conseco Health Insurance Company	877-266-7326	B++	$1,152
Central States Health & Life Company of Omaha	800-442-4029	A-	$1,154
Bankers Life and Casualty Company	312-396-6000	B++	$1,245
Sterling Investors Life Insurance Company	877-604-6606	B	$1,250
State Farm Mutual Automobile Insurance Company	LOCAL	A++	$1,279
Pennsylvania Life Insurance Company	888-802-9497	B++	$1,290
Continental General Insurance Company	800-545-8905	B+	$1,294

Central Reserve Life Insurance Company	800-945-8554	B+	$1,298
Continental Life Insurance Company of Brentwood Tennessee	615-377-1300	B++	$1,304
Order of United Commercial Travelers of America	800-848-0123	NR-4	$1,327
Noridian Mutual Insurance Company (dba Blue Cross Blue Shield of ND)	800-342-4718	NR-5	$1,362
Philadelphia American Life Insurance Company	800-552-7879	B+	$1,397
Union Bankers Insurance Company	800-824-3577	B+	*$1,401
American Family Mutual Insurance Company	800-374-1111	A	$1,405
Sterling Life Insurance Company	800-688-0010	A-	$1,417
Constitution Life Insurance Company	800-789-6364	B++	$1,419
Lincoln Heritage Life Insurance Company	800-438-7180	B++	$1,448
Humana Insurance Company	800-872-7294	A-	$1,501
Equitable Life and Casualty Insurance Company	800-352-5150	B++	$1,525
United Teacher Associates Insurance Company	512-451-2224	A-	$1,595
State Mutual Insurance Company	800-780-3724	B+	$1,602
United National Life Insurance Company of America	800-207-8050	NR-2	$1,627
Guarantee Trust Life Insurance Company	800-338-7452	B+U	$1,658
GE Life and Annuity Assurance Company	800-896-1211	A+	$1,722
Pyramid Life Insurance Company	800-777-1126	B++	$1,811

Oxford Life Insurance Company	608-662-1232	B	$2,080
Standard Life and Accident Insurance Company	800-827-2524	A	$2,080

The following companies base their premiums on issue age which means your premium is based on your age when you purchased the policy. The company will not raise your premium just because you are getting older. Premium may increase based on company experience or due to Medicare changes.

Issue Age:

Company Name	**Phone No.**	**Rating**	**Annual Premium**
Thrivent Financial for Lutherans	800-225-5225	A++	$1,597
United Healthcare Insurance Company	800-523-5800	A+	$1,644
Combined Insurance Company of America	800-544-5531	A	$1,850
Bankers Fidelity Life Insurance Company	404-266-5500	B++	$1,973
United American Insurance Company	972-529-5085	A+	$2,078
Medico Life Insurance Company	800-228-6080	B-	$2,481
Mutual Protective Insurance Company	800-228-6080	B-	$2,481

If you already have a Medicare supplement policy and are considering making a change it is very important that you not cancel your existing coverage until you are certain the new policy is effective.

PREMIUMS AS OF MONDAY, APRIL 04, 2005.

If you have additional questions, please call 1-800-247-0560 or email us at: ndshic@state.nd.us

Brief Description of Plan F
Pick a Different Age
Pick a Different Plan
Return to Medicare Supplement Home Page

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ Other. (please specify)
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

MEDICARE SUPPLEMENT
REVIEW EXERCISE

1. Medicare supplement insurance is sold by the government.
   T _____ F _____

2. Companies can sell Medicare supplement plans with any combination of benefits they choose. T _____ F _____

3. List the basic benefits available under Medicare supplement Plan A.
   a. _____
   b. _____
   c. _____
   d. _____

4. How many of the standardized Medicare supplement plans may be sold in North Dakota? _____

5. Since Medicare supplement insurance was standardized, premiums as well as benefits must be identical from company to company. T _____ F _____

6. Describe the Medicare supplement open enrollment period.
   _____
   _____
   _____

7. If you change Medicare supplement companies after your policy has been in force for two years, you may be subject to a new preexisting condition waiting period.
   T _____ F _____

8. You have 40 days from the time you receive a policy during which you can cancel it and receive a full refund of premium paid. T _____ F _____

9. Providers must file Medicare supplement insurance claims.
   T _____ F _____

10. What does MSN stand for?
    _____

11. What are the three ways Medicare supplement premiums are set? Explain each briefly.

_____

_____

_____

12. Describe why consumers should be cautious if replacing a Medicare supplement policy or purchasing policies that may duplicate coverage.

_____

_____

_____

13. A Medicare beneficiary may purchase as many Medicare supplement policies as he/she chooses. T _____ F _____

SECTION H

OTHER HEALTH INSURANCE

Alternatives to Private Individual Medicare Supplement H-1

Managed Care H-1

Medicare Advantage H-3

Guaranteed Issue for Eligible Persons H-5

Retirement Plans H-7

Group Policies H-9

Limited Benefit Plans H-11

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Disclosure Statements H-19

Other Health Insurance Exercise H-34

Alternatives to Private Individual Medicare Supplement

In some cases, seniors have alternatives to Medicare and Medicare supplement policies available to them. In addition, there are various specialty insurance products on the market which are often marketed to senior adults. Further discussion follows.

Managed Care

Managed care is not new. It was originally developed to provide coordinated care in a cost effective way (1973); designed to control rising costs.

In 1995, over half the U.S. population and 69% of workers were enrolled in some type of managed care plan.

About 12% (2002) of Medicare beneficiaries are enrolled in managed care.

Health care and financing are handled by the same entity/organization.

Managed care organizations or plans contract with CMS to provide Medicare benefits to enrollees. Plans **must** provide all benefits provided by Medicare; they **may** provide additional benefits.

1. **To Qualify for a Medicare Managed Care Plan**

   Must have both Part A and Part B of Medicare and continue paying Part B premium.
   Must live in the area served by the plan (designated by county or zip code).
   Must not be receiving hospice care (can choose if already covered by plan).
   Must not have end stage renal disease (plan must cover care if already enrolled).

2. **How It Works**

   You enroll in the managed care plan.
   You select a primary care physician from the plan's list of providers (also called a gatekeeper).

Your care is coordinated by the primary care physician – he or she must refer you to specialists if needed. Without a referral, the plan generally won't pay.
You may be charged a copayment for doctor visits or other services.
The plan coordinates bills and payments.

3. **Costs**

Medicare Part B premium.
Monthly premium for the managed care plan if there is one.
Copayments for services if required.

NOTE: Managed care plans often offer preventive benefits and other services that are not covered by Medicare, e.g., prescription drugs*, vision, dental.

**Most plans have some type of limit on the amount of drugs that will be covered.*

4. **Managed Care Plans Cannot Refuse to Enroll You Because of Health, Disability, or Preexisting Conditions Except as on Page H-1**

Managed care plans must have at least one 30-day open enrollment period each year. Many offer continuous open enrollment.

Managed care plan benefits and costs may change from year to year.

5. **Summary**

Under a Medicare Managed Care plan you may pay lower costs and receive additional benefits in return for agreeing to see the physicians and use the facilities on the plan's list. If you enroll in a Managed Care plan and later decide to disenroll, you may have difficulty finding a private Medicare supplement. There are some circumstances that may allow you to enroll in certain Medicare supplement plans without difficulty.

Medicare Advantage

All Medicare beneficiaries everywhere continue to have access to original Medicare and private Medicare supplement (though open enrollment is limited). **If you are happy with your current arrangements, you do not need to change.**

Medicare Options

Original Medicare/Medicare Supplement (discussed in Sections D, E, and F)
Managed Care
-- Health Maintenance Organization (HMO)
-- Provider Sponsored Organization (PSO)
-- Preferred Provider Organization (PPO)
Private Fee for Service (PFFS)
Medical Savings Account (MSA)

1. **Medicare HMO** must provide the same benefits available with original Medicare. Beneficiary agrees to use providers who are part of the HMO network.

   You choose a Primary Care Physician (PCP) who coordinates your care. The PCP must authorize your care (including hospitalization and specialist care). If you receive other than emergency or urgent care outside the network, neither the plan nor Medicare will pay (exceptions: women's health specialist; Heart of America HMO).

   In exchange for these "restrictions", beneficiaries (usually) receive more benefits and lower costs (Medicare supplement not necessary).

   Point of Service (POS): Managed care plans may or may not offer a Point of Service option. This allows the beneficiary to receive services out of the network with higher out-of-pocket payment requirements. Each plan may handle the POS benefit differently. There is no standardization and no plan is required to offer a POS.

2. **Provider Sponsored Organization (PSO)** is a group of doctors and hospitals that form their own organization to enroll and treat Medicare beneficiaries. Works like an HMO in that you agree to receive care within the network.

3. **Preferred Provider Organization (PPO)** is a network of providers set up by the health plan. If you choose to go to providers not in the network, the plan will pay less of the cost; you are responsible for the rest.

4. **Private Fee for Service (PFFS)** is a private insurance policy that pays providers for each service (similar to original Medicare). You receive services from any provider. The PFFS plan covers the cost of your care according to its own fee schedule. You may be billed up to 15% more than the plan's fee schedule.

   You pay a monthly premium in addition to the Part B premium. There are no limits on how much the plan can charge in premium.

   This is not managed care.

5. **Medical Savings Accounts (MSA)** consist of a high deductible health insurance policy and a bank savings account. After the deductible is met, the insurance policy must pay for all services covered by Medicare (except hospice care).

   You select a high deductible policy (maximum $6,000 in 1999) and arrange for the savings account. Medicare pays the monthly premiums of the high deductible policy and deposits the difference between that amount and what they would otherwise pay a plan in your area into your MSA savings account.

   Money in the savings account is available to pay for medical services (whether or not they are covered by Medicare - but only Medicare covered services count toward the deductible). When the deductible is met, the insurance policy covers your care. Money in the savings account is tax free and grows tax deferred. Money not used in one year rolls over into the next year.

   There are no limits to what providers can charge and no limits on premiums charged by the insurance company.

   Those selecting this option are locked in for one year.

An MSA may be a network or non-network plan. It is a four-year demonstration project with a maximum enrollment of 390,000 beneficiaries. As of now, none are available.

6. **Private Contracting**: See page E-20 in your SHIC manual.

Guaranteed Issue for Eligible Persons

Eligible Persons - Six Categories:

1. A person enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare or the plan is primary to Medicare **and** the plan terminates or ceases to provide all such supplemental health benefits to the individual.

   Can purchase Medicare supplement plan A, B, C, or F from any company.

2. A person enrolled in a Medicare Advantage plan and circumstances permit discontinuance of enrollment (any **one**):

   a. Plan's certification ends or plan no longer provides services in the area;

   b. Enrollee moves out of the service area;

   c. Plan violates contract provisions or is misrepresented in marketing;

   d. Other exceptional conditions provided by the Secretary of Health and Human Services.

   Can purchase Medicare supplement plan A, B, C, or F from any company.

NOTE: This guaranteed issue provision also applies to Medicare beneficiaries under 65 but only companies that sell to under 65 market are required to offer the coverage.

3. A person enrolled in a Medicare risk or cost HMO, Medicare Select, or demonstration project and circumstances permit discontinuance of enrollment:

   a. Plan's certification ends or plan no longer provides services in the area;

   b. Enrollee moves out of the service area;

   c. Plan violates contract provisions or is misrepresented in marketing;

   d. Other exceptional conditions provided by the Secretary.

   Can purchase Medicare supplement plan A, B, C, or F from any company.

4. A person has a Medicare supplement (Medigap) plan and enrollment ends because:

   a. The company becomes insolvent or bankrupt;

   b. The company substantially violates a provision of the plan;

   c. The company or agent materially misrepresents the insurance policy during the marketing of the policy.

   Can purchase Medicare supplement plan A, B, C, or F from any company.

5. A person has a Medicare supplement (Medigap) plan and:

   a. The person terminates their Medigap coverage (voluntarily); and

   b. The person enrolls in a Medicare Advantage plan, Medicare risk or cost HMO, or Medicare Select **for the first time**; and

   c. The person then disenrolls from the plan within the first 12 months of enrollment (voluntary).

Can purchase the Medicare supplement plan they previously had from the company they were previously with. If that plan is no longer available, they can purchase A, B, C, or F from any company.

6. A person becomes eligible for Medicare Part B benefits at age 65 and:

   a. Enrolls in a Medicare Advantage plan;

   b. Then disenrolls from the plan within 12 months of first enrolling; and

   c. Goes to original Medicare.

   Can purchase any plan offered by any company.

To qualify for guaranteed issue options, a person must:

1. Apply within 63 days of termination or disenrollment.

2. Issuer cannot deny or put conditions when issuing a plan.

3. Cannot discriminate in pricing the plan.

4. Cannot exclude benefits for preexisting conditions.

Plans are required to notify beneficiaries of their rights for guaranteed issue Medicare supplement insurance.

Retirement Plans

Group insurance coverage is a common employment benefit. Some companies may continue to provide health insurance coverage to retired employees.

1. Employment related plans are individualized for each company or organization and vary widely. There are no set standards they must meet.

2. Employer retirement plans may offer benefits that supplement Medicare and may cover expenses excluded by

Medicare or private MedSup insurance (especially preventive care and prescription medication).

3. Employer retirement plans do not have to conform to state or federal Medicare supplement rules.

4. Employer plans may change or even eliminate retirement benefits due to increasing costs or other factors.

5. If a company "self insures," the coverage is not actually an insurance policy and is not regulated by the Insurance Department. The Department of Labor regulates self-insured plans under Employee Retirement Information and Security Act (ERISA) regulations. A company that self-insures is covering employees' health care claims from the company's assets/profits.

    a. If an employer with a self-insured retirement plan goes out of business, retirees would have to look for private MedSup insurance (may qualify for guaranteed issue Medicare supplement under Category 1 - see page H-5).

6. If an employer health insurance plan is available to you after retirement, here are some questions and issues to consider:

    a. Does the plan appear to be secure or is the employer cutting back on benefits?

    b. Does the plan cover the retired person's spouse or other dependents?

    c. Will the spouse/dependent be covered if the retired person dies?

    d. Are there lifetime maximums in the employer's plan? If so, how much of them have been used?

    e. What are the deductibles or copayments of the employer's plan?

    f. Does the employer plan provide dental, vision, hearing, or other coverage?

g. Does the employer plan require use of certain providers?

h. Does the plan cover prescription drugs?

i. How much does the plan cost per month?

7. To fully analyze an employer plan, **you must review a current copy of the plan's benefit booklet.** This can be obtained and additional questions answered by human resource department staff or an employee benefit coordinator.

8. For assistance with claims resolution for self-insured plans, North Dakotans may call the Kansas City Regional office of the Department of Labor at (816) 426-5131 (nationwide toll-free 866-444-3272) or they may write:

Employee Benefits Security Administration
U.S. Department of Labor Regional Office
City Center Square, Suite 1200
1100 Main Street
Kansas City, MO 64105

Group Policies

A **group policy** is a contract between the insurance company and an organization, usually an employer or association. (An individual policy is a contract between one person, the "policyholder", and an insurance company).

1. The organization has a "master contract" and is the "policyholder".

   a. The organization enrolls members or employees who become **"certificate holders"**.

   b. The price of group coverage is often--but not always--lower than similar coverage in an individual contract.

c. Group policyholders can--and do--make changes in their contracts which affect certificate holders. For example, the group policyholder might decide to switch companies or simply to stop offering members anything.

2. When the Group Plan Ends

a. When an employer terminates a group plan, the insurance company may make a conversion option available to employees. That is, the employees may have the option of converting to an individual plan of insurance.

3. When a Member Leaves the Group

a. When employment is terminated, the employer must allow the employee to continue insurance coverage (subject to meeting certain requirements) for a period of time with the employee paying the premium. Consolidated Omnibus Budget Reconciliation Act (COBRA) extensions under federal law apply to companies with 20 or more employees.

(1) The COBRA extension for a "normal" termination is 18 months.

(2) In the case of disability, the COBRA extension is 29 months.

(3) In the case of death or divorce, dependents and spouse are allowed a 36-month extension.

(4) State rules apply to companies with 19 or fewer employees and require a 39-week extension.

b. The insurance company may also offer a conversion option when employment or the extension ends.

c. An extension of coverage may terminate when the covered individual qualifies for Medicare. However,

if the individual is covered by Medicare and becomes eligible for COBRA, they may be covered by both. Please keep in mind enrollment in Part B of Medicare triggers the six-month open enrollment for Medicare supplement insurance.

4. When One Spouse is Medicare Eligible

   a. If a Medicare eligible individual is covered under a working spouse's employer group plan, and employment ends or the plan is terminated, the Medicare eligible spouse would enroll in Medicare and have their six-month open enrollment period in Medicare supplement.

   b. If the group carrier offers Medicare supplement insurance, they might provide a conversion option (i.e., allow the Medicare eligible spouse to convert from the group coverage to a Medicare supplement plan).

5. When the Group Switches

   If the group policyholder switches insurance companies, the new company must offer coverage to everyone who was covered under the old group policy, with continuous coverage and no new conditions. All preexisting conditions covered under the old contract must be covered under the new contract. However, the new policy might (and probably will) have different benefits.

Limited Benefit Plans

There are a number of other types of insurance policies available to senior adults. These may or may not be appropriate purchases. All should be evaluated carefully with consideration given to cost vs. benefits provided and if those benefits are part of other coverage the client has.

Federal legislation passed in August 1996 clarified provisions related to duplication of coverage and also required disclosure statements (included on pages H-19 - H-33).

Federal law still prohibits selling duplicate Medicare supplement policies. **Policies which duplicate benefits available under Medicare are exempt from the prohibition if they pay benefits directly to the beneficiary without regard to other coverage and if the application contains a clear statement disclosing the extent to which the policies pay benefits for services that are also covered by Medicare.**

1. Specific Disease/Accident Policies

    a. Pays only if the person contracts the disease, such as cancer, or has an accident named in the policy.

    b. **This type of plan does not provide basic coverage.**

        (1) Advantages

            (a) May not restrict coverage to Medicare-covered expenses.

            (b) Premiums tend to be low because benefits are so limited.

        (2) Disadvantages

            (a) Pays only in the event the beneficiary contracts the specified disease or is involved in a specific accident.

            (b) May duplicate coverage available through Medicare and Medicare supplement.

            (c) Coverage generally does not keep pace with inflation.

            (d) May limit total amount of coverage.

2. Hospital/Medical Expense Indemnity Policy

    a. Pays a set cash amount or a percentage of the medical expenses while the patient is hospitalized.

b. May pay added benefits--part of the cost of private duty nurse or an amount per day while a person is confined to an SNF intensive care unit or burn unit.

(1) Advantages

(a) Coverage easy to understand.

(b) Available to people under 65 years of age.

(c) Premium rates tend to be stable over time and less than a Medicare supplement.

(d) Pays cash to beneficiary, which can be used for other medical expenses.

(2) Disadvantages

(a) Not as comprehensive as a Medicare supplement policy or HMO (e.g., does not pay anything towards doctor bills).

(b) May reduce benefits after age 65 or 70.

(c) Coverage fails to keep pace with inflation and the rising costs and changes in Medicare cost-sharing provisions.

(d) Updating coverage to match Medicare cost increases results in increased premiums.

(e) Generally, only covers periods of hospitalization with other types of care not covered.

(f) Most not tailored to cover the specific gaps in Medicare.

(g) Often does not begin to pay until a certain day of hospitalization or status as nursing home inpatient, decreasing policyowner's likelihood of ever collecting any benefits. Some policies have a maximum number of days or a maximum payment amount.

(h) As the average length of stay for inpatient hospital care decreases, the value of this type of policy decreases.

QUESTIONS/CHECKLIST FOR THOSE CONSIDERING HMO COVERAGE

1. What is the monthly premium?
   Low option _____ High option _____

   Will I have to pay copayments? If so, how much and what for?

   Low option: _____
   _____

   High option: _____
   _____

2. What are the differences between the low and high option benefits?
   _____
   _____

3. What portion of the doctors are board certified or board eligible? _____

4. Do you have specialists in:

Gerontology	_____
Mental health	_____
Ophthalmology	_____
Orthopedics	_____
Surgery	_____
_____	_____
_____	_____
_____	_____

   What if I need a specialist that is not connected with the HMO?
   _____
   _____

   Will the HMO pay for a second opinion? _____
   Does it have to be from an HMO doctor? _____

5. How many doctors work with the HMO? _____
   How many doctors left the HMO last year? _____

6. Can I <u>choose</u> my primary doctor from those working with the HMO or will I be <u>assigned</u> someone? _____

Are there any restrictions on whom I can pick? _____
Can I switch doctors? _____
Is there a limit on how often I can switch? _____

7. Do I have a choice of locations? _____
How long does it take to get there? _____
Is it difficult to get there from home? _____

8. Will Medicare pay for care I get from a provider or facility not connected to the HMO? _____

9. Do nurse practitioners or physician assistants handle routine office visits? _____

Are the nurse practitioners or physician assistants specially trained to work with older patients? _____

What happens if I want to see a physician instead?
_____
_____

10. How long does it usually take to get an appointment with a primary doctor? _____

How long does it usually take to get an appointment if I need to see a specialist? _____

How long does it take to get an appointment for a check-up? _____

11. Are the entrances wheelchair accessible? _____

Are there staff members who speak:
Sign language _____
German _____
Norwegian _____
Russian _____
Spanish _____
_____ _____

12.___What are your regular hours? _____
Are all services available at all hours? _____

Where do I go for medical care after hours?

_____

_____

Can I call my doctor or physician extender with questions about my care? _____

Are there special times set aside for these calls? _____

13. Are these services available at the same location as my doctor?

Eyeglasses	_____
Health education	_____
Laboratory	_____
Pharmacy	_____
X-ray	_____
_____	_____
_____	_____

14. Where will I go for hospital care? _____
Does this hospital have an intensive care unit? _____
Which nursing homes are used? _____

_____

15. Do I have to get permission before being treated for nonemergency care when I am away? _____

What do I do if I need care while out of town?

_____

_____

What paperwork do I need to submit to get reimbursed if I receive care while out of town?

_____

_____

Do these papers have to be turned in within a certain time? _____

How long does it take to get reimbursed? _____

16. What percentage of HMO members dropped out voluntarily last year? _____

17. How much notice will I need to give if I want to drop out? _____

When will my notice become effective? Can I rejoin the HMO later? _____

18. Are there conditions that the HMO will not treat?

_____

_____

19. What are the most common types of complaints that are made about the HMO?

_____

_____

_____

20. How many members are there? _____
How many are Medicare beneficiaries? _____
How long have you been providing Medicare services? _____
Is there a member Advisory Committee? _____
Are Medicare beneficiaries on the committee? _____
Do members have a seat on the Board of Directors? _____

Which groups are represented on the board?

_____

_____

_____

Which local businesses belong?

_____

_____

_____

NOTE: It is suggested that you visit the HMO to gather your own impressions and make your own judgment. You may also want to visit with current members on whether they would recommend the HMO and what they like/dislike about the services or staff.

APPENDIX C

DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries That Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

• hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

• any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

• hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• hospice
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

• any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• hospice
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

• any expenses or services covered by the policy are also covered by Medicare; or
• it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• hospice care
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

• the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization
• physician services
• hospice
• other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

OTHER HEALTH INSURANCE EXERCISE

TRUE OR FALSE

1. An HMO assigns a primary doctor to each member. T F

2. Since a company that "self-insures" the health coverage it provides for employees/retirees actually covers claims from the company's assets/profits, the plan would not be regulated by the North Dakota Insurance Department. T F

3. Limited benefit plans must pay benefits directly to the beneficiary without regard to other coverage. T F

4. HMOs do not cover emergency care received outside of their network. T F

5. HMOs often provide services that Medigap policies do not cover (e.g., preventive care). T F

6. A limited benefit insurance policy should be the first priority of seniors when assessing their insurance needs. T F

7. Retirement health plans that are coordinated benefits plans are the most generous and least common type of retirement plans because they generally cover whatever Medicare does not cover. T F

SHORT ANSWER

8. _____ provides for extension of a health plan for a specified period of time in cases of termination of employment, disability, death, or divorce.

9. The _____ is a retirement health plan available to Medicare beneficiaries who were employed by the State of North Dakota and paid into the Public Employees Retirement System.

10. Explain why premiums for limited benefit plans are generally quite low.

_____

11. Name four criteria for eligibility in a Medicare HMO.
    a. _____
    b. _____
    c. _____
    d. _____

12. _____ insurance plans are heavily marketed to seniors and often duplicate Medicare and Medicare supplement coverage.

MATCHING

_____ 13. Provider network

_____ 14. Health maintenance organization

_____ 15. Balance billing

_____ 16. Gatekeeper

_____ 17. Case management

_____ 18. Disclosure statement

a. A primary physician in an HMO who coordinates a patient's care within the service network.

b. The amount a consumer is billed for a particular service when the provider is reimbursed by the insurer at a rate lower than charged.

c. Comprehensive medical services provided by a designated network of providers on a monthly prepaid basis.

d. The channeling of all medical information into one file per patient, and the review and supervision of each patient's medical care by one primary physician.

e. A group of health care professionals who have agreed to provide services to an HMO or insurer at a specific rate.

f. Statement which discloses how the benefits of a limited benefit plan duplicate Medicare coverage.

SECTION I

LONG-TERM CARE INSURANCE

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What Is Long-Term Care?

The term "long-term care" describes a wide range of services intended to provide for the health, personal care, and social needs of chronically ill or infirm individuals. Long-term care may become necessary as a result of prolonged illness, injury leading to disability, or aging.

1. Long-term care can range from simple help with daily activities at home (e.g., bathing and dressing) to highly skilled nursing care. It can be provided in a variety of settings.

2. We usually think of long-term care as being in a nursing home--and nursing home care is a significant part of long-term care. Other services which may help people live at home or outside a nursing home include:

   Assisted living facilities.

   Basic care facilities.

   Home health care.

   Home and community based services waivered services.

   Adult day care.

   Adult family homes.

   Congregate care facilities or continuing care retirement communities (CCRCs).

   Personal care.

NOTE: The State Health Department Division of Health Facilities brochure “Choices in Care” describes several options. It may be obtained by calling (701) 328-2352.

Who Will Need Long-Term Care?

Not all individuals will need long-term care.

1. There are a number of factors that are likely to influence whether or not an individual will need nursing home care.

   a. **Women** are more likely to need nursing home care. Women live longer, making them more likely to develop chronic health problems and more likely to live alone. Approximately 72 percent of nursing home residents are women, with 84 percent of them being widowed, single, divorced, or separated.

   b. Elderly **widows and widowers** are five times more likely to enter a nursing home than their married counterparts.

   c. Family and individual **health history** plays an important role in determining future risk of needing long-term care.

      (1) **Circulatory disease** is the primary diagnosis at admission for about 30 percent of nursing home residents.

      (2) It is estimated that over 60 percent of nursing home residents have some level of cognitive impairment or senility.

2. Traditionally, long-term care has been provided informally by spouses, family, friends, and neighbors and 75 percent of all long-term care is provided by family members. Reliance on family for long-term care is becoming more difficult because:

   a. Women have traditionally provided most informal long-term care for family members and an increasing number of women now work outside the home.

   b. Families are more geographically scattered and family size is smaller.

c. Spouses and children of persons needing long-term care (age 85+) are themselves older and less able to provide care and support.

3. The need for long-term care will grow in the years ahead because people are living longer. Interestingly, the older you are, the longer your life expectancy:

   a. An average 50 year old can expect to live to 83 years.

   b. At 60, life expectancy is 84.2 years.

   c. At 70, life expectancy is 86 years.

   d. At 80, life expectancy is 89.5 years.

   e. At 90, life expectancy is 95 years.

4. **Most nursing home stays are short, e.g., recuperation from an acute condition (heart attack or broken hip) before returning home.** These shorter stays have been encouraged by the way Medicare pays for hospital care.

   (Remember, Medicare pays hospitals a flat rate for a particular condition, regardless of how long the patient is in the hospital. This encourages hospitals to discharge patients as early as possible, often to nursing homes. Also, see page D-15 for information provided to Medicare beneficiaries when hospitalized.)

   a. National statistics indicate that 45 percent of all people over 65 will spend some time in a nursing home.

      (1) Five percent will spend one to two years confined,

      (2) Nine percent will spend between two and five years confined, and

      (3) Less than 20 percent will spend more than three years in a nursing home.

b. The average length of stay in a nursing home in North Dakota is one year.

c. The number of persons with more than one nursing home stay is significant. **Nearly half of all persons discharged from a nursing home will reenter** at some point in their life. Twenty-five percent had three or more admissions in their lifetime.

Cost and Financing of Long-Term Care

Not many older adults can afford long-term care costs for very long.

1. The **average** cost of a year in a nursing home in North Dakota is about $50,000 ($137 per day). (Daily rates may vary depending on level of care required.)

2. Medical inflation is generally double regular inflation and has averaged eight percent over the last five years. At that rate, a nursing home costing $130 per day today would cost $606 per day in 20 years.

3. Nationally, just over one-half of all nursing home expenses are paid out-of-pocket by individuals and their families.

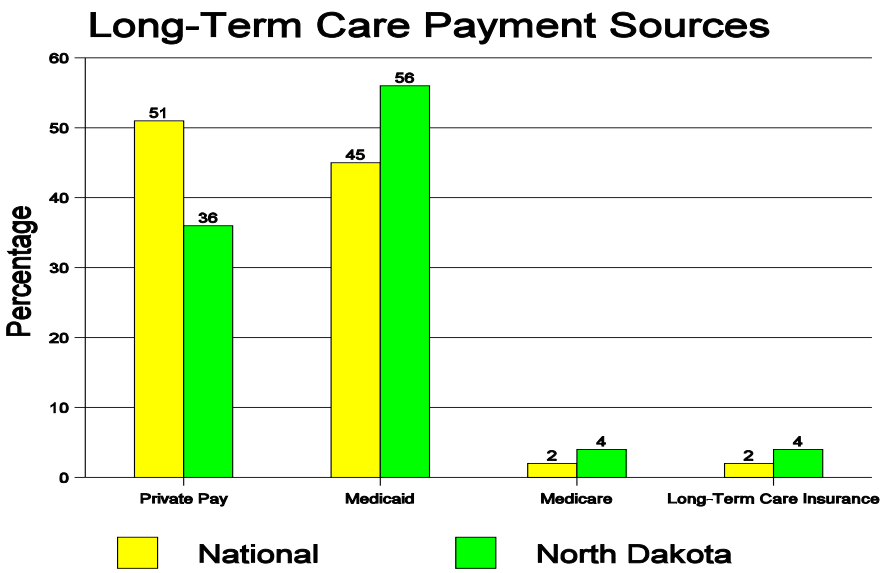
4. Slightly less than one-half of nursing home expenses nationally are paid by state Medicaid programs.

5. **Medicare pays less than less than four percent of nursing home bills in North Dakota.**

6. Medicare supplement insurance and employer health insurance seldom pay anything toward nursing home care.

7. Private long-term care (nursing home) insurance paid less than two percent of nursing home expenses nationally in 1987. In North Dakota, as of 1995, about four percent of nursing home expenses were paid by long-term care insurance.

The following chart illustrates the sources of payment for long-term care nationally and in North Dakota.



Medicare and Long-Term Care

Many people mistakenly believe that Medicare covers long-term care. Actually, Medicare pays only a very small percentage of all nursing home costs. **Medicare is not designed to cover the bulk of long-term care expenses.**

1. Medicare pays **only for skilled nursing care following an approved hospital stay** provided the patient meets other stringent criteria. Medicare **does not** pay for basic or custodial care which is what most people entering a nursing home need.

2. Even if the patient qualifies, Medicare Part A pays **only 20 days** in full and 80 more days in part.

3. While the average nursing home stay for patients in a single nursing facility is about 450 days, Medicare has historically only paid for an average of 27 days of covered care per year. **Medicare should be considered as little or no help for long-term care needs.**

Medicaid

Medicaid is the government program which pays the bulk of nursing home costs and some home and community based services. It is the federal/state/local medical assistance program designed to financially subsidize individuals who cannot afford the cost of the nursing home.

Individuals must meet certain medical and financial criteria to qualify. Eligibility requirements vary from state to state.

Medicaid is discussed in more detail in Section I.

For case specific information, contact the nearest Social Services office (telephone numbers are listed on page N-6).

Private Long-Term Care Insurance

Private long-term care insurance is a fairly new product designed specifically to cover nursing home care and other long-term care services. Long-term care insurance policies have evolved considerably over the last 10 years. **There is no standardization and policies vary widely. There is no open enrollment or other guarantee of coverage.**

1. Nationally there are about 3.7 million long-term care insurance policies in force.

2. In North Dakota, there are about 28,000 long-term care policies in force. This figure represents policies purchased by all age groups, not just seniors.

3. **Long-term care insurance is generally defined as "any policy or certificate advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred or indemnity basis, provided in a setting other than an acute care unit of a hospital."**

NOTE: Insurance policies offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident

coverage, or limited benefit health coverage are **not** considered long-term care insurance.

a. Long-term care insurance is considered health insurance and North Dakota's health insurance regulations apply.

b. Life insurance policies which accelerate the death benefit specifically for one or more qualifying events are not considered long-term care insurance. Terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement are common "qualifying events". The policy provisions usually provide the option of a lump-sum payment for those benefits and neither the benefits or the eligibility for the benefits is conditioned upon the receipt of long-term care.

c. Long-term care insurance is meant to provide coverage for the most catastrophic expense. In long-term care, this expense is **room and board and nursing care in nursing homes**. This insurance may **not** cover all of an individual's long-term care expenses, such as doctor visits, therapy, personal care supplies, and prescriptions. (Some of these, e.g., doctor visits and therapy, may be covered by Medicare.)

d. Types of long-term care insurance policies sold are nursing home care only, home health care and community-based care only, or a combination of both. (Community-based care includes adult day care, respite care, etc.)

Who Should Buy Long-Term Care Insurance?

Many people will need some type of long-term care service in their lifetime. However, not everyone should purchase long-term care insurance.

1. Anyone considering the purchase of long-term care insurance should ask themselves a number of questions and evaluate their specific circumstances carefully before making a decision.

   NOTE: In some cases, people may not want to reveal or discuss the answers to these questions. That is their choice. The important thing is that they are aware of and have considered these issues.

2. People asking the question, "Do I need a long-term care insurance policy?", must evaluate their financial, emotional, and lifestyle preferences and needs. The following issues/areas should be considered:

   a. **General health.** Keep in mind that all long-term care insurance policies are underwritten. A person in poor health, if able to purchase a policy at all, may have to pay a very high premium. The healthier a person is, the more likely they are to be able to purchase long-term care insurance. On the other hand, they may be less likely to need it.

   b. **Living arrangements.** Do you live alone? With spouse or other adult, relative, or friend? Would your living partner be willing to care for you in the home? How do you feel about family or friends providing care for you?

   c. **Assets and resources.** Consider monthly income, expenses, and calculate **as realistically as possible** the amount available to pay long-term care premiums. Recognize that long-term care premiums may increase from year to year. Those on limited, fixed incomes or who have trouble making ends meet each month should probably not purchase long-term care insurance. Individuals or couples with assets they wish to pass on to children or others may want to consider long-term care insurance as a means of protecting those assets.

North Dakota Laws and Rules

North Dakota statutes and regulations include some consumer protections for purchasers of long-term care policies.

1. **Prior hospitalization** as a condition of eligibility for benefits **cannot be required** by the policy (effective for policies issued after July 1, 1990).

2. Policies sold today cannot require higher levels of care before they pay at lower levels. Example: If a policy states it will pay for **both** skilled care and intermediate care, it **cannot** require the policyholder to receive skilled care **before** paying for intermediate care. Some older policies may still require a higher level of care before they pay at lower levels. **This does not mean every policy covers every level of care.**

3. **Six months is the maximum** allowed for a waiting period on preexisting conditions.

4. Long-term care insurance policies must be at least **guaranteed renewable**. This means they cannot be canceled unless the premium is not paid. Policies can also be **"noncancellable"** which means the company may not raise the premium.

5. Long-term care insurance **premiums are "level"**. This means the premium cannot increase as one's age increases. However, if a company can demonstrate their need for additional premium dollars to cover claims being paid, North Dakota law requires that an increase be approved. Such an increase would apply to everyone with the same policy form number.

6. The **option** to purchase **an inflation protection feature** must be offered to each applicant at the time of purchase.

7. Coverage for Alzheimer's disease and other conditions of organic origin **may not be excluded** by a long-term care insurance policy.

8. Beginning July 1, 1994, prospective purchasers of long-term care insurance must receive a **Long-Term Care Insurance Shopper's Guide** prior to presentation of an application or enrollment form if agent solicited or in connection with the application or enrollment form if direct response. **Notice of the availability of the SHIC program is also required to be provided.**

9. The policyholder has a **30-day free-look period**. Within 30 days of its delivery or the effective date of the policy, whichever is later, the policy may be returned for a full premium refund if the buyer is not satisfied for any reason.

10. Group long-term care policies must include a provision to provide covered individuals with an option to **continue or convert** their coverage when coverage under the group policy is about to terminate. This option is available to those who have been insured under the group policy for a minimum of six months. The individual does not have to prove insurability for the new coverage.

11. When dealing with clients 65 or older, agents are required to "have reasonable grounds at the time of sale for believing that the recommendation is suitable for the consumer and shall make reasonable inquiries to determine suitability." Considerations include:

    a. Income and assets.

    b. Client's need for insurance.

    c. Current insurance vs. suggested insurance.

12. To protect older policyholders from unintentional lapse, companies must offer clients the opportunity to designate a third party to whom notice will be sent 30 days after a premium is due and unpaid. If a person chooses not to designate a third party, they must sign a waiver.

    a. If the insurer is provided with proof of cognitive impairment or loss of functional capacity <u>and</u> if a request is made within five months after termination of the policy <u>and</u> if past due premiums are paid, the policy may be reinstated.

Consumer Choices In Long-Term Care Products

Long-term care products are not standardized like Medicare supplement plans. Therefore, consumers have many choices to make and each will affect the price of the product. This section provides an overview of long-term care policy features.

1. **Indemnity v. expense policies**

   a. Long-term care insurance is usually the **indemnity** type, meaning that it pays a fixed amount for each day care is received. Example: An $80/day benefit means the policy would pay $80 each day of care, regardless of the actual cost of care.

   b. An **expense** policy pays the actual daily charge up to a maximum daily benefit. Example: An $80/day benefit means the policy will pay the actual charge up to a maximum of $80/day. If the actual charge is $75/day, the policy pays $75/day. If the actual charge is $90/day, the policy pays $80/day.

   c. Daily benefits may range from $40 per day to $200 per day. The higher the daily benefit, the more costly the premium.

2. **Benefit period and maximum benefits**

   a. The person purchasing the policy chooses the term or duration of coverage. Most plans are purchased for a specific period of time, for example, one, three, or five years. **The longer the benefit period, the more costly the premium.**

   b. Some policies may provide for more than one "benefit period". A benefit period is generally defined as "the time for which payments for benefits of an insurance policy are available."

      In long-term care policies, if a benefit period limits the number of **consecutive** days for which coverage is paid, the insured could exhaust his/her benefits before reaching the policy's maximum benefit.

c. Some policies define maximum benefits in terms of time, usually a set number of days. For example, on the schedule page of the policy, the words "maximum benefit" will be followed by a number of days or years or "lifetime".

d. Some policies define maximum benefits in dollars. This means benefits will be paid up to a maximum dollar amount for services covered. (The maximum benefit notation on the schedule page would be followed by a dollar figure.)

3. **Elimination period**

a. This term applies to the number of days the individual must be in a nursing home before the long-term care insurance product will begin paying its benefits. **The elimination period is the same as a deductible and must be met before the plan will pay.** An individual needs to decide how long they can/want to pay for their own care to make a decision on this option.

b. Most plans offer a choice of elimination or waiting periods. Common choices are 0, 20, and 100 days. A plan with a 0-day elimination period will begin paying its benefits on the first day of eligible nursing home care. A plan with a 20-day elimination will begin paying on the 21st day of eligible care. The individual is responsible for paying charges incurred during the elimination period. **The shorter the elimination period, the higher the cost of the premium.**

c. If an individual requires more than one stay in a nursing home, some policies may waive additional elimination periods after the individual has met the initial one.

READ THE POLICY!

d. Remember that about 52 percent of nursing home residents stay in a nursing home less than 90 days. If a consumer buys a plan with a 100-day elimination period, he/she may be out of the nursing home before any benefits are due to be paid.

4. **Inflation adjustment**

a. Due to inflation, a policy that pays $50 per day will not be worth $50 per day in 10 years. In North Dakota, companies offering long-term care insurance are required to offer an **inflation protection option**.

b. Some policies provide an automatic benefit increase each year (generally five percent a year for the first 10 years) in order to protect against the rising costs of long-term care.

c. Other companies may offer the policyholder the right to purchase more daily benefits in later years without regard to changes in the health of the individual.

d. Inflation adjustments can be helpful but will cause the premiums to be higher. **Read the policy carefully.** Frequently, if an inflation option is not exercised the first time it is available, it will not be available again.

General Notes on Long-Term Care

There are other features and issues that should be understood when considering purchase of long-term care insurance.

1. **Underwriting and health questions**

a. **Underwriting** is one of the ways companies try to control levels of risk. Most companies ask detailed health questions before deciding to insure the applicant. Some require a medical history or physical examination. They are especially sensitive to such risks as heart problems, leukemia,

rheumatoid arthritis, Alzheimer's, Parkinson's, and those people already bedridden or with mental or physical disorders. The companies would rather decline your business than assume a bad risk.

(1) Applicants should make sure their health questionnaire is complete and accurate.

Fill it out yourself.

Review it thoroughly if someone else fills it out.

Answer all questions completely and honestly.

(2) If a policy or certificate has been in force for two years, the policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health. The policy or certificate may not be contested based upon misrepresentation alone.

b. **Preexisting condition.** Health questions on the application assist companies in determining whether a person has any preexisting conditions. Policies usually will not pay benefits arising from a preexisting condition for a specified amount of time (waiting period) after the effective date of the policy. Generally, a preexisting condition is defined as "any condition for which you have sought or received medical advice or treatment within the past six months." Six months is also the maximum a company can impose as a preexisting condition waiting period for long-term care insurance.

2. **Renewability of policy and premium**

a. All long-term care policies are guaranteed renewable for life. **Guaranteed renewable** means the insurance **company cannot cancel** the policy as long

as the premium is paid on time. The premium cannot be raised unless it is raised for all policyholders in the same class based on the claims experience for that block of business. All rate increases must be filed with and approved by the Department of Insurance.

3. **Waiver of premiums**

(3) a. Most companies have a **"waiver of premium"** feature. After an insured enters the nursing home or facility and benefits are paid for a specified number of days, no further premiums will be due while the confinement continues. Premiums resume if the patient leaves the nursing home before policy benefits are exhausted. The policy will tell you how this feature is handled.

b. The typical waiver of premium feature takes effect after 90 days of a covered stay. Counting for the premium waiver **usually** starts after the elimination period has run.

4. **Services covered**

a. Long-term care policies may pay for skilled, intermediate, or custodial care in a nursing home, home health care, and other home and community-based services (adult day care, respite care). **Each policy may define these terms differently.** It is important to understand these definitions because **benefits will be provided only if the care received is covered under the policy**.

b. Policies generally pay for care only in facilities or by providers that are, at a minimum, licensed by the state. **Check the definitions section of the policy to find the specific facility/provider standards required in order to receive benefits.**

c. Licensed assisted living facilities. Any facility that holds itself out as an assisted living facility must be licensed by the Department of Human Services.

Licensing does not guarantee that a long term care policy will cover stays in an assisted living facility. As stated above, **benefits will be provided only if the care received meets policy requirements**.

5. **Benefit trigger/insured event**

a. A benefit trigger is the **event or condition that must be present for the policy to begin paying benefits**. The same benefit triggers in a policy must be met to access all of the levels of care. Terms typically used in policies to describe when benefits are triggered are:

Activities of daily living (ADLs)

Cognitive impairment

Medically necessary or injury or sickness

b. **"Medically necessary"** and **"injury or sickness"** are both subject to the insurance company's and the insured's doctor's interpretations. If a person needed custodial care in a nursing home due to inabilities of old age (forgetfulness, frailty, etc.), a policy using "medically necessary" or "injury and sickness" as benefit triggers might not pay benefits.

c. **Activities of daily living** (ADLs) usually include some or all of the following: bathing, dressing, feeding, transferring, mobility, toileting, and/or continence.

(1) This benefit trigger means the insured must need help with a certain number of ADLs before the policy begins paying benefits. For example, it could require 2 deficiencies out of 5 ADLs or 3 out of 6. These differing trigger requirements are difficult to compare since one "2 of 5" ADL requirement may be more difficult for a person to meet than another, depending on which ADLs are used.

Example: Bathing is usually the first ADL skill an elderly person loses. A "2 of 5" ADL requirement without bathing may be just as restrictive as a "3 of 6" ADL requirement that has bathing.

(2) The policy may use words such as "hands on", "continual one to one", "supervisory", "stand by", "reminding-directional", substantial help from another person, or any combination of these to define "deficiencies" or "need of assistance". A requirement of "hands-on" assistance is more restrictive than a requirement of "stand-by" assistance.

d. **Cognitive impairment** relates to the mental ability to safely care for oneself. This is an important inclusion because many persons with Alzheimer's disease may need long-term care even though they may not be deficient in any ADLs. Such a person may be able to dress, feed, and bath herself without hands-on assistance, and yet not be able to care for herself safely due to wandering and forgetfulness.

e. It is also important to know who is the **certifier of the benefit trigger**. When the policyholder believes he/she needs long-term care, who should be contacted? Who will determine whether the benefit trigger has been met and whether the policy will begin paying benefits? Is it a doctor, a case worker, or a representative of the company? This answer should be found in the Benefits section of the policy.

6. **Typical exclusions** found in policies include:

Alcoholism and drug addiction.

Preexisting conditions or diseases.

Mental or nervous disorders, except Alzheimer's or related degenerative and dementing illnesses.

Conditions caused by suicide, attempted suicide, or intentionally self-inflicted injury.

Services provided by a member of immediate family.

Services already paid for by government (except Medicaid), workers compensation, or motor vehicle no-fault law.

7. **Cost of long-term care insurance**

a. **Two of the principal factors** companies use to determine the amount of **premium** the individual will pay are:

Age.

Amount of benefits (daily and maximum).

b. The younger the individual is when the policy is purchased, the less expensive the premium.

(1) A 25 year old may buy a certain policy for $8 per month, while that same policy for a 75 year old may cost $250-$350 per month.

(2) Premium cost is determined by age at the time the policy is issued and does not increase **due to age** as the policyholder grows older.

c. Length of the benefit payment and daily benefit amounts have a significant effect on the premium.

d. Benefits, such as home health care coverage, inflation protection, and nonforfeiture benefits may also increase the premium.

e. The insurance agent can quote an exact price **only after** the applicant has selected his/her options and features.

Other Potential Features of Long-Term Care Plans

As long-term care policies have evolved, the options available for purchase have increased.

1. Some policies cover medications, x-rays, and physical exams during a nursing home stay. Some policies cover such services as hospice, some ambulance charges, adult day care, and homemaker services. Please keep in mind benefit triggers must be met to access other types of care.

2. Some policies offer **nonforfeiture benefits**. Should a person choose to cancel the coverage or if coverage lapses because s/he forgot or could not pay the premium, nonforfeiture benefits would return part of the investment in the policy. These would probably not be paid in cash; however, the company may guarantee some portion of the policy's benefits after the lapse/cancellation occurred. In order to receive a reduced benefit, premiums must have been paid for a minimum number of years.

3. Some policies offer a **paid-up premium feature**. This option is not common and not approved for North Dakota policy filings.

4. **Return of premium** is an option of some policies; however, the North Dakota Insurance Department is not approving policies with this feature.

5. Some insurance companies contract for the services of a case manager to assess an individual's need for care, devise a treatment plan, and monitor the care that is given.

6. **Most of the "extras" offered in a policy will raise the premium.**

Tax-Qualified Long-Term Care Insurance Policies

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a category of long-term care insurance policies called "tax qualified" plans. Policies must meet certain federal standards in order to be considered tax qualified plans.

1. Qualified plans must use specific eligibility standards.

   a. The insured must be certified by a licensed health care professional to be "chronically ill" and have a plan of care (must be recertified annually).

2. To be considered chronically ill, a person must meet one of two standards:

   a. S/he is expected to be unable, without substantial help from another person, to do at least two of five (or six) Activities of Daily Living (ADLs) for at least 90 days.

      NOTE: ADLs are bathing, dressing, toileting, transferring, eating, and continence. States may allow companies to choose which five ADLs to include or can require companies to use all six. In **North Dakota**, companies may use five or six ADLs but bathing must be one.

   b. A person must need substantial supervision to protect their health and safety because of a cognitive impairment.

3. Benefits received from a tax-qualified long-term care policy are generally not taxable as income.

4. Benefits received from a policy that is not a tax-qualified long-term care policy **may** be taxable as income (Treasury Department has yet to issue regulations).

5. Individuals with tax-qualified long-term care plans may be able to deduct all or part of the premium.

   a. The long-term care premium can be added to other deductible medical expenses.

   b. To claim a tax deduction, all of your medical expenses must be more than 7.5 percent of your adjusted gross income.

Age	Premium Amount for Tax Deduction (2003 Returns)
40 years old or less	$250
41 to 50 years old	$470
51 to 60 years old	$940
61 to 70 years old	$2,510
71 years old or older	$3,130

NOTE: Tax qualified long-term care policies are not allowed to make a payment when Medicare pays, even on days 21-100 of nursing home care when a daily copayment is due.

6. Long-term care policies issued before January 1, 1997, are automatically considered tax qualified unless disqualifying "material changes" are made.

Tax-Qualified Policies	Non Tax-Qualified Policies
1. Premiums can be included with other annual uncompensated medical expenses for deductions from your income in excess of 7.5% of adjusted gross income up to a maximum amount adjusted for inflation.	1. You can't deduct any part of your annual premiums.
2. Benefits that you may receive will not be counted as income.	2. Benefits that you may receive may or may not count as income. The U.S. Department of the Treasury has not yet ruled on this issue.
3. Benefit triggers may be more restrictive than those which may be allowed in non tax-qualified policies. The federal law requires you be unable to do 2 of 5 out of 6 possible ADLs without **substantial assistance**.	3. Policies can offer a different combination of benefit triggers. Benefit triggers may not be restricted to 2 of 6 ADLs.
4. "Medical necessity" can't be used as a trigger for benefits.	4. "Medical necessity" and/or other measures of disability can be offered as benefit triggers.
5. Disability must be expected to last for at least 90 days.	5. Policies don't have to require that the disability be expected to last for at least 90 days.
6. For cognitive impairment to be covered, a person must require "substantial supervision".	6. Policies don't have to require "substantial supervision" to trigger benefits for cognitive impairments.

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Tips For Buying Insurance

Here are some issues people should review and consider before purchasing a long-term care insurance policy.

1. Determine the motivation and/or need for long-term care by asking certain questions.

    a. Do I have enough income to pay my own way without insurance?

    b. Is it reasonable to spend my own money, deplete my assets, and then apply for Medicaid?

    c. Is there any reason to preserve my assets for heirs or are there no heirs?

    d. Would I prefer to make a long-term care decision now rather than to leave such for my family?

    e. Do I have enough income to pay a portion of the nursing home costs and then rely on a small long-term care policy for the remainder, i.e., a $50 per day policy?

2. Once the reason for long-term care insurance is ascertained, then it is important to carefully select features which are appropriate for you. Consider the following issues:

    a. Do not buy a $100 per day policy if you only need $50 per day.

    b. Remember that **nursing home costs** increase yearly and premium costs may increase as well.

    c. The premium is more reasonable if you purchase a policy at a younger age.

    d. Medical necessity may be important. Most people are institutionalized at the custodial level first which is essentially nonmedical.

    e. Consider your very long-term care goals. Most people who enter a skilled facility, for instance, eventually go home.

f. Remember that one-half of all people using a nursing home stay less than 90 days.

g. Remember that only about 12 percent of the population over 65 ever uses a nursing home for an extended length of time, i.e., several months or more.

3. Many people over 65 cannot afford long-term care insurance because of their fixed and limited incomes. If purchasing such insurance strains the budget, other options should be considered. Remember, the odds are on your side. There is nearly a 90 percent chance that you will not even need long-term care past 90 days.

4. Dealings with insurance agents

a. Do not submit to high pressure tactics.

b. Do not rely on the information orally submitted by the agent. Read the policy yourself.

c. If you are dissatisfied, take advantage of the 30-day free-look period and return your policy to the company, not to the agent.

d. Always pay by check (not cash). Make checks payable to the insurance company, not the agent.

e. Compare several polices before buying and READ THE SMALL PRINT.

f. Write down the agent's name, address, and telephone number.

g. Be sure the insurance company's product is approved for sale in your state and check the company rating (measure of financial stability).

h. Inquire if any administrative action has been taken against the company.

i. Request information on the premium history (have there been rate increases; if so, how much and how often).

NOTE: The State Insurance Department should be able to provide information noted in Items g, h, and i.

Duplicate Coverage and Policy Replacement

There is no federal or state prohibition against the purchase of more than one long term care insurance policy as there is with Medicare supplements; however, it may not be advisable to own more than one. There is an increased cost to the policyholder because each policy carries its own administrative costs. Understanding and keeping track of more than one policy may be burdensome. Before purchasing an additional policy, it may be advisable to consider increasing the coverage on the first. Pursuing this option is generally considered to be "replacement" but it may be the better choice. There are situations when it is reasonable to have more than one policy. A case in point might be when an older policy has coverage limits that can be supplemented by a newer policy. An example might be if the first policy requires a three-day hospital stay, a clause no longer permitted in long term care insurance policies.

Replacing a policy, especially with a different company, brings important factors into consideration. Under certain circumstances the new policy may place preexisting conditions clauses on some coverages for six months. Or it may exclude coverage altogether for certain medical conditions. In addition, most premiums are based on recovering generally high initial costs of issuing a policy.

If replacement is being considered because the premium on the existing policy has become too high, the owner should ask the existing company if reductions in policy benefits would reduce the premium. This cost could then be compared to the cost of a new policy from another company.

Because of the seriousness of duplicating coverage and policy replacement, the Insurance Department places specific requirements on insurance companies and agents. Among them are questions that must be in the application designed to determine if the applicant has another long term care policy or certificate in force and/or whether it is to replace another policy or certificate

currently in force. The questions include asking if the applicant is on Medicaid, the name of the insurance company/companies that issued the other policy/policies, and if the new policy will replace any other coverage. Agents must also list other health insurance policies they have sold to the applicant. If replacement is involved, the agent must furnish a notice that addresses these issues. The applicant must date and sign the notice. A copy of the notice is to be given to the applicant and a copy retained by the company.

LONG-TERM CARE REVIEW

1. Besides a nursing home, where else may long-term care be provided? List three.
   a. _____ b. _____ c. _____

2. Not many older adults can afford long-term care costs for very long.
   T _____ F _____

3. Medicare pays only for _____ nursing care.

4. What government program covers the bulk of nursing home costs:
   _____

5. In North Dakota, a long-term care insurance policy must cover all levels of long-term care. T _____ F _____

6. Alzheimer's disease may not be excluded once the policy becomes effective.
   T _____ F _____

7. Some plans offer long-term care benefits for as long as you stay in a nursing home.
   T _____ F _____

8. What is meant by "inflation adjustment"?
   _____
   _____

9. It is important that an applicant fill out his/her own health questionnaire.
   T _____ F _____

10. A person living on a limited, fixed income should purchase long-term care insurance. T _____ F _____

11. What are some tips a counselor could give someone who is considering buying a long-term care policy?
    _____
    _____

12. Name three factors which increase the risk of needing nursing home care.

13. Why does Medicare rarely pay for nursing home care?

14. Name three factors clients must make a decision on which will affect their premium.

15. Define the following terms:

    Premium waiver

    Benefit trigger

    Expense policy

    Indemnity policy

16. Name three consumer protection features in long-term care insurance.

17. Name three common benefit "triggers".

18. For a long-term care policy to be a “tax-qualified” plan, it must use specific eligibility standards.
    T _____ F _____

19. Benefits received from a tax-qualified plan are generally not _____.

20. Under what circumstances would it make sense to replace a long-term care insurance policy?

SECTION J

MEDICAID AND PUBLIC BENEFITS

Differences Between Medicaid and Medicare J-1

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Qualified Medicare Beneficiary (QMB) J-7

Special Low Income Medicare Beneficiary (SLMB) J-8

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Differences Between Medicaid and Medicare

	Medicaid	Medicare
Function	Primarily for low-income people and complements Supplemental Security Income (SSI) and Temporary Assistance to Needy Families (TANF) programs	Primarily for people over age 65 and complements regular Social Security benefits/ retiree health program
Funding	Federal and state	Medicare Trust Funds (strictly federal) and premiums
Operations	Operates as assistance program Does not require significant financial contributions from program participants	Operates as insurance program Beneficiaries pay premiums and deductibles
Adminis-tration	Federal-state partnership States administer program under broad Centers for Medicare and Medicaid Services (CMS) guidelines Programs vary from state to state	Federal program solely Administered by federal agencies including CMS and the Social Security Administration (SSA) Program is uniform among the states
Eligibility	Means-tested, depends on medical need, income, and resources (in some coverages); varies by state Must be 65 and over, blind, disabled, or pregnant. Also, children under 21 and caretakers of deprived children.	Depends on contributions to Social Security system while employed Must be 65 or older Also covers certain disabled people and people who buy in

	Medicaid	Medicare
Services and Coverage	Covers inpatient and outpatient hospital, physician, and therapy services Physical exams and immunizations Dental care, prescription drugs, eyeglasses, and transportation with limits May buy private health insurance for working poor or elderly if policy cost is less than Medicaid benefits May cover home and community-based care Covers long-term care	Parts A and B provide basic hospital, physician, therapy, limited skilled nursing facility services, home health care, and hospice Limited prevention-oriented health services

Medicaid Program Overview

Medicaid, also called Medical Assistance (MA) and Title XIX, is a program for certain low-income people (children, pregnant women, aged, i.e., over 65, blind, and disabled).

1. Medicaid is the health program supplement for two major financial assistance programs.

   a. Supplemental Security Income (SSI), and

   b. TANF (Its connection with Medicaid is not detailed here.)

2. Medicaid is a "needs-based" program (means-tested). Applicants must prove that their income and sometimes their assets are below certain levels which indicate need.

3. The Medicaid program was enacted by Congress in 1965. It is a joint federal and state program.

4. Medicaid is supervised by the North Dakota Department of Human Services, Division of Medical Services.

   a. It is administered by 51 county social service offices.

   b. Applications for Medicaid are processed by the county social service office in the county where the individual lives.

      (1) Processing time is 45 days for families with children and aged persons.

      (2) 90 days for disabled individuals when disability determination is pending.

         (a) Social Security Administration disability decision is binding.

   c. The state Medicaid office has assigned specific counties to regional economic assistance representatives. Call (701) 328-2332 (800-755-2716) to speak with the representative for your county.

5. Medicaid in North Dakota covers:

   a. Categorically needy (mandated to cover):

      (1) IV-E foster care.

      (2) IV-E adoption assistance.

      (3) Supplemental security income recipients.

      (4) Families with children under 21.

   b. Categorically needy (elected to cover):

      (1) Non-IV-E foster care.

      (2) Non-IV-E sub-adopt.

(3) Uninsured women under age 65 who have breast or cervical cancer (Women's Way Program).

c. Medically needy (elected to cover):

(1) Caretakers, pregnant women, and children under age 21.

(2) Aged, blind, and disabled.

d. Poverty level (mandated to cover):

(1) Pregnant women and children age 5 and under at 133% poverty level and children age 6 through 18 at 100% poverty level.

(2) Qualified Medicare beneficiaries (can also be on Medicaid).

(3) Special low income Medicare beneficiaries (can also be on Medicaid).

(4) Qualifying Individual 1 (cannot be receiving other Medicaid benefits).

6. Applicants must meet technical <u>and</u> financial eligibility requirements:

a. **Technical eligibility** includes citizenship, residence, age, deprivation, disability, and incapacity.

b. **Financial eligibility** includes consideration of income (and assets in some coverages).

c. Eligibility may begin three months prior to the month of application **except for QMBs**.

(1) QMBs are eligible no earlier than the month <u>after</u> the month they are determined eligible.

7. Medical care and services covered by Medicaid include:

   a. Physician services (with limits).

   b. Inpatient and outpatient hospital care (with limits).

   c. Laboratory and x-ray.

   d. Drugs.

   e. Dental care (with limits).

   f. Eye care (with limits).

   g. Long-term care (does not include custodial care).

   h. Nonmedical home and community based services (includes homemaker services, personal care, adult day care, rehabilitation services, chore services, and respite care; see page J-9 for more complete descriptions of these services).

   i. Home health care.

   j. Chiropractic services (with limits).

   k. Osteopath services.

   l. Diagnostic screening and preventative services.

   m. Physical and occupational therapy (with limits).

   n. Podiatric services.

   o. Transportation to obtain medical care (with limits).

8. Asset limits and exemptions:

   a. The combined equity value of liquid, personal, and real property (assets) may not exceed $3,000 for one person or $6,000 for two people.

b. Exempt assets include:

(1) Home.

(2) Vehicle.

(3) Clothes and personal effects.

(4) Household goods and furniture.

(5) Term insurance.

c. Assets considered unavailable include:

(1) Nonsalable property (can be temporarily excluded).

(2) Income producing property when the individual is actively engaged in producing that income.

(3) Separate-identifiable account designated for burial. This could be a savings account or a whole life policy or annuity. The value of the burial fund up to $3,000 per person is not counted toward the $3,000/$6,000 asset limits.

9. **Spousal impoverishment.** In the case of a married couple when one person is institutionalized or receiving home and community based services, the ineligible community spouse may keep up to half of the couple's countable assets as of the date of institutionalization or receipt of home and community based services, up to a maximum of $95,100* with a minimum of $19,020*.

The ineligible community spouse may also keep all their own income and income from the institutionalized spouse if needed to bring the income to $2,267 per month (Minimum Monthly Maintenance Needs Allowance) in the year of application. (More than $2,267 may be "deemed" to the community spouse if ordered by the court.) Income from the institutionalized spouse must be available to other family members residing in the home to bring their income to $505* per month.

* 2005 figures - changes January of each year.
** 2005 figures - changes April of each year.

10. Disqualifying transfer of property:

    a. Transfer of any property without adequate compensation may cause ineligibility for long-term care services or home and community-based services.

    b. The look-back period is 36 months from the date that an institutionalized individual is both institutionalized, AND has applied for Medicaid (the first date both criteria are met).

    When the transfer was to or from a trust (ANY kind of trust), the look-back period is 60 months.

    The look-back period is not in any way a cap on the length of the period of ineligibility. It is merely the amount of time prior to application/ institutionalization during which transfers are subject to the new transfer provision.

Qualified Medicare Beneficiary (QMB)

The **Qualified Medicare Beneficiary** (QMB) program was enacted by Congress to:

1. Provide assistance to low income elderly or low income disabled who are Medicare eligible.

2. The QMB program will pay Part B premium and the Part A premium for those who do not receive it free, Medicare deductibles, and coinsurance for eligible individuals. To qualify, individuals must be enrolled in Medicare Part A.

3. Countable income (see note on page J-9) may not exceed 100 percent of the federal poverty level* per month for an individual or for a couple (both over 65 and eligible for Part A). Countable income is determined by subtracting $20 from gross monthly income.

4. Countable resources may not exceed $4,000 for an individual or $6,000 for a couple. Exclusions include:

    a. Residence and all contiguous acres.

    b. Life insurance with face value up to $1,500.

c. Burial space items for individual and immediate family, or the $3,000 Medicaid burial exclusion.

d. Burial funds (separately identifiable).

* Check with your county social services office or contact SHIC program staff for updated information. Changes April of each year.

Special Low Income Medicare Beneficiary (SLMB)

The **Special Low Income Medicare Beneficiary** (SLMB) program took effect January 1, 1993:

1. Available to older or disabled persons with slightly higher income (100-120 percent of federal poverty level).

2. Pays Medicare Part B premium.

3. Countable income must be between 100 and 120 percent of the federal poverty level per month for an individual or for a couple.

4. Individual must be enrolled in Medicare Part A.

Qualifying Individual-1 (QI-1)

1. Available to older or disabled persons with slightly higher income (120-135 percent of federal poverty level).

2. Pays Medicare Part B premium.

3. Countable income must be between 120 and 135 percent of federal poverty level per month for an individual or for a couple and they may not otherwise be eligible for Medicaid benefits.

4. Individual must be enrolled in Medicare Part A.

Application for QMB, SLMB, and QI-1is made through the county social service office. These coverage groups are referred to as Medicare Savings Programs.

NOTE: Countable income includes the Part B premium which is deducted from the Social Security check.

Public Benefits

The **Older Americans Act** provides states with federal funds for services to persons age 60 and over, especially those who are low income, socially needy, frail, or minority members. **Aging Services** is responsible for administration of these funds. Actual services are primarily delivered by local nonprofit senior services providers and include:

1. **Nutrition Services**. Meal services are provided to the home-bound and also at facilities where older persons congregate, such as senior centers.

2. **Access/In Home Services.** Provides services such as transportation, outreach, chores, and health maintenance to persons 60 and over in their own homes and communities.

3. **Elder Rights.** Provides advocacy to assure access to legal services, benefits counseling, and protective arrangements for vulnerable adults.

4. **Long-Term Care Ombudsman Program**. Ombudsmen are impartial mediators for residents of long-term care facilities. They investigate complaints and resolve issues affecting residents, their family, friends, and facility staff.

Home and Community Based Care

Aging Services also administers four programs to assist functionally impaired older individuals and persons with a physical disability to remain in their own homes by paying for personal, environmental, and community based services.

1. Of these funds:

    a. **Medicaid Waiver for the Aged and Disabled** is available to individuals who are 65 and over, or disabled individuals under 65 who meet Social Security disability criteria, who are receiving Medicaid and require skilled nursing level of care.

    b. Medicaid waiver for the **Traumatic Brain Injured Waiver (TBI)** is available to individuals with a traumatic or acquired brain injury, is 18 years of age or older who are disabled based on Social Security

disability criteria, require skilled nursing level of care, and receive Medicaid.

c. **Service Payments for the Elderly and Disabled (SPED)** are available to individuals with less than $50,000 in assets who are not eligible for the waiver programs and have been impaired for at least three months in four activities of daily living (ADLs) or five independent activities of daily living (IADLs).

d. **Expanded SPED** is available to Medicaid recipients who are impaired in three of four IADLs (meals, housework, laundry, and medication), need supervision or a structured environment, and are not severely impaired in toileting, transferring, or eating.

2. County social services undertakes an assessment of the applicant to determine if the eligibility criteria are met and to identify which of the following services are necessary to maintain independence. Not all services are available under each program.

3. **Personal care services** are available to assist clients with daily activities such as bathing, toileting, and dressing.

a. **Personal care** is daily or intermittent care provided to an individual within their home usually by a non-family member.

b. **Family home care** is 24-hour room, board, supervision, and other care provided to the individual by a family member either in their home or the caregiver's home.

c. **Respite care** is provided by a non-family member temporarily and periodically to relieve the primary caregiver of the stress and demands of continuous care.

d. **Adult family foster care** is 24-hour room, board, supervision, and other care provided in a caregiver's home to those adults unable to function independently who may benefit from a family home environment.

4. **Environmental services** are assistance with tasks around the home.

   a. **Chore service** is the provision of home maintenance such as seasonal cleaning, minor home repair, and walk care. This service is available to homeowners as well as renters, provided that the rental agreement does not cover these tasks.

   b. **Homemaker service** is the provision of nonpersonal tasks such as housekeeping, laundry, and shopping.

5. **Community-based services** are offered which increase the individual's mobility within the community.

   a. **Nonmedical transportation** enables access to essential community services such as grocery stores and pharmacies.

   b. **Adult day care** is a program of social and related support services provided to individuals 18 years and older on a regularly scheduled basis in order to insure their optimum level of functioning.

Federal Entitlement Programs

1. **Social Security** is a federally operated retirement program. Eligibility is open to:

   a. Workers aged 62+.

   b. The disabled.

   c. A divorced spouse (at least 10 years of marriage) of a Social Security recipient, or who cares for the recipient's minor or disabled child.

   d. A widow(er) or divorced spouse (at least 10 years of marriage) aged 60+ or cares for deceased's minor or disabled child.

   e. Parent aged 62+ who was supported by a deceased child.

2. **Supplemental Security Income** is a federal income assistance program for individuals who meet **all** of these criteria:

   a. U.S. citizens or legal aliens.

   b. 65+ or blind or disabled.

   c. Monthly income other than wages of not more than $579 per month for a single or $869 per month for a couple.*

   d. Assets of not more than $2,000 for a single person or $3,000 for a married couple. A $1,500 burial plan is also allowed.

   Some people with earned income (wages) may also qualify for SSI. Check with the nearest Social Security office (see page N-7) for further information.

* Changes January of each year.

State/ County Assistance Programs

1. **Medicaid** (see pages J-2 through J-7).

2. **QMB/SLMB QI-1** (see page J-7).

3. **Hill-Burton Free Care.** Some hospital and nursing home facilities are obligated to provide free care under the Hill-Burton law. Other facilities voluntarily provide charitable care. Application should be made with the facility if the client is unable to pay for care and the client is ineligible for Medicaid.

4. **Food stamps** are available if:

   a. Gross monthly income does not exceed $1,009 for a single person or $1,354 for a couple (updated 10/04). If you are 60 or older or disabled, net income is used. It must not exceed $776 for a single person or $1,041 for a couple.

   b. As of October 1, 2000, the asset test was eliminated.

5. **General assistance** is available if:

   a. An emergency exists with regard to food, shelter, utilities, medical, or burial costs; or

   b. The person is receiving SSI and lives in a basic care facility.

   c. Counties may open eligibility to other categories of residents as well.

6. **Low income home energy assistance program** is administered by the Department of Human Services and is available to clients with:

   a. Gross yearly income of less than $16,580 for a single person or $21,681 for a couple.

   b. Less than $8,000 in assets. An additional $2000 in assets are allowed per household member over age 60.

7. **Property tax/rent credits** are available to adults aged 65+ or disabled if:

   a. They own a home and their annual household income is less than $14,000 and their total assets are less than $50,000, excluding the unencumbered value of your homestead up to $80,000.

   b. They are renters with an annual household income less than $14,000 and 20 percent of the annual rent is greater than 4 percent of their annual income.

   Contact the North Dakota Tax Department for more information at 1-800-638-2901.

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DUAL ELIGIBLE INCOME LIMITS FOR 2005
BASED ON PERCENTAGE OF FEDERAL POVERTY LEVEL

[illegible]	
QMB (100% FPL)	Annual/Monthly
Individual	$9,570 / $798
Couple	$12,830 / $1,070

[illegible]	
SLMB (120% FPL)	Annual/Monthly
Individual	$11,484 / $957
Couple	$15,396/ $1,283

[illegible]	
QIs (135% FPL)	Annual/Monthly
Individual	$12,919 / $1,077
Couple	$17,320 / $1,444

[illegible]	
QDWI (200% FPL)	Annual/Monthly
Individual	19,140/$1,595
Couple	25,660/$2,139

North Dakota criteria for all Medicare Savings Programs

- **Assets**
  - **$4,000 for one person**
  - **6,000 for two persons**

QMB

- **Eligible the month following the month of determination**

SLMB

- **Eligible up to three months prior to the month of application**

QI

- **Cannot be on any other Medicaid coverage group**
- **Eligible up to three months prior to the month of application**

Spousal Impoverishment Levels			
Community Spouse Minimum Asset Allowance (effective 01/01/05)	**Community Spouse Maximum Asset Allowance (effective 01/01/05)**	**Community Spouse Income Level (effective 01/01/04)**	**Income Level for each Additional Individual (effective 04/01/05)**
$19,020	$95,100	$2,267	$534

Average Cost of Nursing Care	
Average Monthly Cost of Care (effective 01/01/05)	**Average Daily Cost of Care (effective 01/01/05)**
$4395.00	$144.48

SECTION K

COUNSELING SKILLS AND PROBLEM SOLVING

Communication Skills K-1

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Commu-nication Skills

As a Counselor, you will be called upon **to provide accurate, objective health insurance information in a supportive manner that will enable the client to make well-informed decisions.**

Effective interpersonal and communication skills play an important role in providing services. Your own good nature and good judgment form the base of your communication style.

During a counseling session, you can draw upon many communication techniques to facilitate understanding between you and your clients:

Review Client Agreement Form
Provide assurances of confidentiality
Treat your client with **respect** from your initial contact through all phases of the service you provide
Ask **clarifying questions** to focus the discussion
Ask **"open-ended" questions** to clarify information and to check that you understand key points
Maintain a **cordial** but professional tone throughout your interactions with the client
Listen supportively and patiently as the client describes his/her situation
Observe signs of anxiety or misunderstanding and provide appropriate assurances to ease your client's discomfort
Summarize often during conversations with your client to confirm that you understand the client's situation
Take care to **define terms and explain concepts** in ways the client will understand
Provide **precise explanations** paced appropriately to avoid misunderstanding
Encourage the **client's participation** in pursuing ways to resolve his/her health insurance-related problems
Remain flexible about your ideas for resolving problems and be open to your client's ideas

Obtain the **client's approval** before taking action on his/her behalf

Preparing for a Counseling Session

When a counseling session is scheduled, the **client** should be advised to bring to the meeting:

Health insurance policies
Claim forms
Medical bills
Medicare card
Copies of relevant correspondence pertaining to the claim being reviewed.
A relative or trusted friend may also attend the session.

The **counselor** should assemble the materials and information necessary to conduct a productive meeting. Depending on the client's concern, useful information to have with you includes:

Client agreement
Counseling report form
Existing files about the client, if available
Referral information
Policy comparison forms
Calculator

Beforehand, confirm that the meeting site is available as scheduled and that your client will be able to meet with you as planned. Get to the meeting site a few minutes ahead of time to see that things are in order and to be able to greet your client when s/he arrives.

Counseling Guidelines

Besides applying the interpersonal and communication skills discussed earlier in this chapter, you can assure a productive meeting by following several routine procedures.

A counseling session might include the following elements. The counselor should keep the discussion focused to make best use of the time allotted.

1. **Introduce yourself**

After introducing yourself, use the "Client Agreement" sheet to brief the client on what counselors can and cannot do in the counseling relationship.

2. **Help the client feel comfortable**

To help put the client at ease, ask a few questions about how the person is doing or something else that will put the client at ease. The intent is to make the client more comfortable and help him/her to open up. Good introductions include, "How are you today", a comment about the weather, or a compliment on an article of clothing.

3. **Ask client to describe problem**

Ask why s/he has come to see you and how s/he heard about the program. Be sure to listen carefully to how the client describes the problem. It may take a while to get to what the real problem is. People often talk in circles and do not get at the real issue immediately.

4. **Restate the client's problem back to client**

After carefully listening to the client describe the problem to you, restate what you heard as the problem. **For example, you might say,**

> "What I heard you say is that you need help organizing your Explanation of Medicare Benefits (EOMB's) that have piled up over the last few months . . . ."

Ask if you are correct in your understanding of the issue. Remember to use "I" statements as much as possible so that you refer to only what you heard and not necessarily what the other person actually said.

5. **Develop a strategy to address the issue**

Once you are sure you understand your client's problem, think about how you want to address this issue.

Options:

a. Research the problem by **using your manual**; find the answer or develop a strategy based on what you discover in the manual.

b. After looking in your manual, if you have a question, **consult** with another counselor, your coordinator, or contact the Insurance Department for suggestions.

c. You might **call other organizations or resource people** for advice in handling this case (see Section N for telephone numbers).

d. If the problem is still confusing or falls outside the scope of your training, refer the client to another agency that may provide assistance. Whenever you make a referral, try to make sure the client is connected to a specific staff person in the agency. Some clients may be able to proceed on their own. Others may need to be "transferred" directly to another person. Often, older adults are unfamiliar with the system and organizations that work on Medicare issues. Some may be uncomfortable making contacts with state or federal agencies. Be sure to document steps you take.

6. **Discuss the problem-solving strategy with client and then decide on next steps for action**

Once you have developed a strategy to address the issue, inform your client of:

What you will do.

What s/he should do.

The time frame involved (e.g., I will do this tomorrow, this will take three weeks).

Let the client know when you will contact him/her for the next steps or to assure him/her that the issue is resolved. Be sure to get the client's telephone number.

7. **Develop client's ability to take care of this problem next time**

If the client's problem is fairly simple, like organizing bills, filing EOMBs, or supplemental insurance statements, you should be able to give some advice to help organize the bills in the future or suggest steps to follow when filing claims. Many people simply need a few good suggestions to get organized. Other issues may be more complicated. Some clients may need more than one session to reach an understanding of the system or to resolve their concerns.

8. **Close the case and record the service on your counseling report forms**

Be sure you let the client know when you believe the problem is solved and the case is closed. Invite the person to contact you again if the need occurs. Also, encourage clients to inform their acquaintances about this service. Before you close a case, ask how the client heard about this service so we can assess our outreach efforts.

Additionally, be sure to fill out the counseling report form and leave it with or return it to the sponsor. The sponsor will forward them to the Insurance Department monthly.

By keeping accurate records of the number of people you serve and the kinds of problems you handle, the Insurance Department and HCFA will get a better

picture of how well Medicare and the counseling program are working and how we can better meet your needs as a counselor.

The following outline highlights topics to consider when conducting a counseling session to ensure that all necessary questions are asked in the process of discussing your client's health insurance concerns. Which sections of this outline you actually use, or to what extent, depend on the questions or problems the client poses.

Qualify the Client

1. **Check Medicare eligibility**

   Is client over 65 and eligible for Medicare?

   Is client under 65 but on Social Security disability?

   Check client's Medicare card for Parts A and B.

2. **Inquire about need; consider eligibility for QMB, SLMB, or Medicaid**

   Determine your client's monthly income to determine eligibility for Medicaid or QMB.

   It is usually not appropriate to simply ask about a client's income or financial resources. One way to handle this might be to say, "There are a couple of programs available to assist you if finances (or health insurance premiums or Medicare premiums) are a problem. Would you like more information about those?"

   If the client expresses interest, you can provide information on the income guidelines from Section I. You could also

provide a contact telephone number (the county social services office) or assist in setting up an appointment for an eligibility evaluation.

The client may not need to buy private health insurance if s/he can obtain Medicaid or QMB.

If Medicaid or QMB coverage preceded the purchases or renewal of the client's current Medicare supplement insurance or other insurance health plans, contact the State Insurance Commissioner's office about a premium refund.

The client may not need the policy if s/he is a low income person. If the policy was purchased recently, the client could return the policy within 30 days for full premium refund.

3. **Federal retirees, mine, or railroad workers**

If the client is a retired U.S. federal employee, miner, or railroad worker, s/he may be covered by a special U.S. government retirement medical plan. Some of these plans take the place of Medicare and Medicare supplement insurance. If someone has questions about the federal retirement insurance plan, they should contact the personnel office of the agency from which they retired. If there is a local chapter of NARFE (National Association of Retired Federal Employees), they may also be able to assist. Some people have the government plan plus Medicare. If so, they might want to carry the plan's low option to reduce the premium.

4. **Eligibility for other programs/services**

The client may be eligible for medical treatment through government services (e.g., the V.A., Military Hospital, or Indian Health Services). Check to see if these options are available. If so, the client may not need supplement coverage for large medical expenses, if premium cost is a major factor. Ask about the client's health because this affects the amount and type of insurance s/he will want to consider.

If the client is considering purchase of additional insurance, ask if they have decided how much a month they can afford for health insurance.

Explain Medicare

1. Use the Medicare summary chart (in the "Guide" or Medicare Handbook) to show the client what Medicare will pay and will not pay.

2. Analyze the basic Medicare gaps:

Under Part A - hospital and nursing home care

Hospital deductible and coinsurance.

Hospital care beyond 150 days.

Intermediate and custodial care.

Under Part B - doctor and medical services

Explain the difference between Medicare's approved charge and the doctor's actual bill.

Explain that the Medicare-approved charge is usually less than the doctor's bill

and that Medicare only pays 80 percent of the "approved charge".

Medicare does not provide worldwide coverage.

Medicare does not pay for outpatient prescription drugs.

Medicare was never intended to pay for everything!

Discuss Protection vs. Cost For Private Insurance

The question to consider here is insurance coverage needed vs. cost.

1. Most basic gaps in Medicare can be filled with the purchase of one Medicare supplement policy. However, neither Medicare nor Medicare supplement policies will cover long-term care costs.

2. The client will have to determine how much money s/he can afford for insurance. Complete coverage can be very expensive. Is the coverage worth it? Probability vs. possibility should be considered by the client.

If the client does not have his/her personal insurance policy at the meeting,

STOP HERE!!!!

Do not try to answer any questions about policies unless you have them in your hands! The risks of misinformation are too great!

Analyze the Client's Medicare Supplement Policy

1. Use the Medicare Supplement Comparison Form provided, refer to Section F of this manual or to the "Guide to Health Insurance for People With Medicare".

2. Check the client's actual policy to determine:

   Exact name of insurance company.

   Form number.

   Name of insurance contract.

   Additional coverage.

   The same insurance company may have several similar policies. Some carriers may come out with a new policy or policies every year. Be careful!

   If the "old" policy was replaced with a new policy, check for a replacement form. The law requires the selling agent to have the purchaser sign a replacement form at the time of the sale.

Analyze the Client's Long-Term Care Policy (If Applicable)

1. Help the individual understand the terms used in long-term care policies (see Section H of this manual):

   Definitions of covered nursing facilities.

   Elimination period.

   Maximum length of benefit.

   Waiver of premium.

   Renewability.

   Premium.

2. Assist the client in understanding the benefits of the contract.

3. Encourage the client to discuss his/her insurance needs and amount of benefits to purchase with other family members, trusted friends, or professionals such as an accountant or lawyer.

Summarize the Gaps

1. If the client has more than one policy, repeat the process for each contract.

2. Help the client understand where there are gaps or duplicate coverage. **The counselor should never advise a client to discontinue or purchase a particular policy.**

Counseling Guidelines Summary

1. Avoid making decisions for your client.

2. Encourage clients to act on their own behalf.

3. Treat your client in a caring manner. Be supportive as well as professional.

4. Be sure you understand the question the person is asking before you provide an answer.

5. Learn as much as you can about Medicare and Medicare supplement as well as long-term care insurance ... and keep on learning.

6. When in doubt, say so. Follow up to get the right answer.

7. Do not tell your client that the problem will be resolved by the courts.

8. Be alert to claim/appeal time limits.

9. Before the meeting ends, agree on what further contact is needed.

10. Complete the paperwork on the session.

11. Remember to keep all client information confidential.

RELAX

1. It is not a crime if you do not know the answer to every question asked about Medicare, Medicare supplement coverage, or LTC plans. No one knows it all ... even experts.

2. You are offering seniors a free service that is unique in your state.

3. You have everything you need to handle most cases.

4. Don't worry about small details. Settle down and help the client.

5. If you are not sure ... do not provide an answer!!!

   a. When in doubt take the client's name, telephone number, questions, and policy form number, if applicable, and promise to follow up.

   b. Tell the client you will call in several days after you have explored the questions or after you have contacted other sources for guidance.

6. Even experts have to check with other experts in specialized areas.

7. As a certified counselor, you may know more about Medicare, Medicare supplement insurance, and long-term care insurance than many insurance professionals in the United States.

8. The only "sin" and embarrassment is to give faulty information!!!

9. Use the knowledge and information that you know to be accurate. You will do a fine job for the client.

10. **Remember everything a client tells you is confidential.**

SORTING AND SOLVING CLAIMS PROBLEMS

Mr. Jones shows up for his counseling appointment with a shoe box full of paper. He is perplexed, concerned, upset. The paper is a mixture of bills and explanations, all covered with numbers and dollar signs. He is not sure who has paid what and suspects he is getting the short end of the stick.

Your job: Help him make sense of it all.

What's the Problem?

You need some information from the client to get you started:

1. What does he **think** happened?

2. **Why** does he believe this?

Mr. Smith may be right or wrong, or a little of each. But his perception of the problem will help get you started in the right direction.

Check Out the Policy

Start by reviewing any insurance policy that is involved.

1. You **must** have the actual policy, outline of coverage, or benefits booklet for review in order to provide help. DO NOT GUESS ABOUT POLICY PROVISIONS.

2. Read the documents to see what benefits are covered as well as what things are excluded. If the client's concern has been more specific, then look for the section that would be most relevant.

3. The solution may jump right at you ("Aha! This policy does not cover elective surgery when performed in Outer Mongolia!").

4. But if the answer is not yet obvious, set the policy aside. And come back to it once you have sorted out the paper.

Sorting

Typically, you will be reviewing several items when helping to file or follow up on a claim:

1. The insurance policy.

2. Insurance identification cards.

3. Relevant medical bills and statements indicating dates services were rendered and amounts of payments.

4. Correspondence including explanation of benefits, notices, statements of payments, and denial notices.

Sort and resort. First, put all things of one kind together, then put them into order by date of service and provider.

1. Separate "Explanation of Benefits" notices from bills.

2. Separate medical bills by provider.

3. Arrange bills from each provider in order of date of services rendered.

4. Arrange "Explanation of Benefits" by carrier (insurance companies, employers, Medicare) and then into order according to the date of service.

5. Read any letters (from the doctor, insurance company, or Medicare). The letters, like the client's perception, can help point you in the right direction.

Matching

The next step is to match documents that relate to the same service date. Clip them all together.

Recording

Use the "Claim Information Sheet" (page E-19) to help analyze what has happened with the bills.

1. Enter the items in order of the date of service starting with the earliest and ending with the most recent.

2. Look for Medicare or insurance company checks that may have been made payable to the client and never received by the provider.

3. Record all amounts and check numbers of patient payments.

4. It is not always easy to determine whether a deductible or coinsurance amount has been "paid" or simply deducted from the amount of the bill.

Analyzing and Problem Solving

Now the fun begins! You know what the client **thinks** is the problem. Now you have got to figure out what it really is. Just what you are looking for will vary from case to case. **Possibilities** include:

1. Double Bills or Payments. If you find more than one bill or EOMB that appears to be for the same service, it may be either a duplicate or a mistake.

2. Unbilled MedSup. Medicare has paid it in part and returned the bill to the doctor because the MedSup company does not have a direct billing ("crossover") arrangement with Medicare. The bill now has to get to the MedSup carrier.

3. UCR. The bills add up to a lot more than the insurance payments because the doctor has charged more than the company's usual, customary, and reasonable charge. You will have to review the policy's payment provisions to see if this is proper.

4. Assignment Violated. The doctor was supposed to take assignment but is billing the patient more than Medicare has approved. The client should check first with the doctor to verify assignment status and whether the bill is a mistake. You may have to refer the complaint to Medicare.

5. Procedures Disallowed. The insurance company (or Medicare) claims a particular service is not covered and so has not paid for it. Check the policy for specific

exclusions. If unresolved, refer the consumer to the Department of Insurance.

6. Insurance Paid Patient Directly. The doctor is dunning her patient because the insurance company paid the patient. If correct, the patient may, indeed, owe the doctor.

7. Etc., Etc., Etc. !!!!

Don't Guess

If you encounter something you do not understand:

1. Offer to do the research necessary to obtain accurate information and arrange to follow up with the client as soon as possible.

2. You may also discover that your client's concerns extend beyond the scope of SHIC.

3. Inform the client of the appropriate referral resources and offer to make the initial contact for your client.

Counseling

Whenever possible, try to demonstrate useful ways for your client to organize his/her medical files. The Claim Information Sheet is a useful tool for organizing important information. Encourage your client's participation as you review his/her claims situation, as you fill in the Claims Information Sheet and as you determine ways to assure maximum payment.

1. Make sure your client understands your assessment of the circumstances and approves all actions to be taken to resolve claims-related concerns.

   a. Provide precise and thorough explanations and encourage questions to assure the most informative session for your client.

   b. After you have carefully explained the appropriate steps to take to resolve a problem, encourage your client to do his/her own follow up.

2. There may be times when your client needs an advocate to act on his/her behalf in resolving a claims-related issue. As a result of your objective assessment of the situation during your discussion with your client, you will be in a position to determine if advocacy is required and to make recommendations for appropriate action.

   a. Be flexible about your ideas for resolving your client's difficulties. Remember the client is not obligated to follow your suggested course of action.

   b. Whenever in doubt, call program staff at the Insurance Department hotline, 1-800-247-0560.

   c. Review your conclusions with the client and confirm that the client approves of your course of action. Establish realistic follow-up dates and arrange for a future meeting if necessary. Give the client a written list of things to do and when to do them.

   d. As soon as possible after the session, make a record of what transpired and provide the report to your coordinator.

Avoiding the Shoe Box Syndrome!

A few tips you can give your client to help make sense of future medical claims.

Get a large calendar to use for medical information only.
Note all appointments on the calendar; indicate name of provider and type of service received.
Make a list of telephone numbers for all contact people and organizations. Include:

Doctors' offices
Hospital billing office
Insurance company (usually a toll-free number)
Pharmacy
Other medical providers
Insurance agent
SHIC: 1-800-247-0560 or 328-2977 in Bismarck/Mandan

Customer Satisfaction

Government programs and those who work in or with them are not always perceived as being customer oriented. Like many other state agencies, the North Dakota Insurance Department strives to erase that perception. As a consumer protection agency, the Department seeks to go beyond "good service" by aiming for "customer satisfaction". Following are suggestions for achieving customer satisfaction. These brief summaries are intended to provide food for thought as you work with SHIC clients.

This section provides ideas on several topics:

1. Dealing with difficult clients.

2. Listening skills.

3. Telephone calls.

4. Training clients (e.g., claims filing process).

5. Customer satisfaction in general.

Active Listening

Becoming a better listener adds to your credibility, makes you a better problem solver, and teaches others to communicate better.

1. **Don't interrupt.** Hear the complete message before you respond to it.

2. **Take notes** to help organize your thoughts. It will encourage the speaker to stick to the point.

3. **Delay evaluation** of the speaker and the topic. Concentrate on the message.

4. **Don't rehearse** your answer as you listen.

5. **Restate the content** of what you have heard to clarify implications or conclusions.

6. **Ask for specifics** to hold down on abstract talk and exaggeration.

7. **Always summarize** agreements and plans before you end a conversation.

Training Skills

When teaching clients how to file a claim or appeal, or sort and track paperwork, here are critical steps to keep in mind:

1. **Tell them** what you want them to do.

2. Take time to **show them** how to do it--each step.

3. **Let them try**--have a "hands on" activity.

4. **Watch** their demonstration.

5. **Manage** the demonstration.

6. Provide information, **feedback**, and a pat on the back.

Telephone Calls

Do you pick up the telephone by the first, second, or third ring? Do you identify yourself? What do you do when you cannot help the caller? Here are a few tips (some may apply only to sponsors):

1. Answer the telephone **promptly**--by the third ring.

2. **Identify** yourself (and your organization).

3. Use the client's **correct name**, don't guess.

4. Speak **clearly**.

5. Put a **smile** in your voice.

6. If you cannot help the client, **refer** them to someone who can.

7. If you promise to call back, **follow through**. Provide status reports when there is a long wait.

8. Say **thank you**.

Upset/ Angry

You will need to calm the client and move them toward solving the problem.

1. **Take it professionally, not personally.**

   Express respect, ignore snide remarks/sarcasm, watch for your early warning signs. Use a buddy system or reschedule if a cooling off period is necessary.

2. **Deal with the emotions first.**

   Let them vent without interruptions, listen to understand, ask open-ended questions, and give empathetic feedback.

3. **Deal with the PROBLEM.**

   Determine the specifics of the problem, ask closed-ended questions, take notes, and restate the key issues. Identify

client expectations--what outcome do they want? How would they handle the problem?

4. **Outline the alternatives.**

   Concentrate on the "cans" not the "cannots". Tell the client what you can do for them.

5. **Agree on a solution.**

   Which of the alternatives does the client choose? What can be done to assist them?

6. **Take action and follow through.**

   If possible, do something extra.

7. **Double-check for satisfaction.**

NOTE: Remember, the customer is not always right--but from their perspective they are.

General Dos

1. Provide **extra service**.

2. Be **culturally sensitive/aware**.

3. Speak the client's **language** (i.e., avoid acronyms and jargon).

4. **Understand** the client--their perception of the problem and their needs.

5. Take **ownership** of the problems that are presented.

6. Strive for **self-improvement**--identify skills that need development.

7. Build client **relationships**--make the process as easy as possible, build trust, and show appreciation.

8. Have a **positive attitude** and **take initiative**.

9. Learn to spot the signs of **burnout** and prevent it.

General Don'ts

1. **Interrupt.**
2. **Assume** you know what the client wants or what he/she will say next.
3. **Lose sight** of the customer's problem due to exaggerations, sarcasm, or personal attacks.
4. Seek someone to **blame** for the problem.
5. **Argue** with a client.
6. Say, "You **have** to . . ."
7. Say, "**The only** thing that can be done . . ."
8. List the things you **cannot** do.
9. Share **internal problems** with clients.

WHAT COUNSELORS WILL DO

I will try to answer any questions you may have about Medicare, supplemental insurance, or long-term care insurance. If I cannot provide you with the answer during our counseling session, I will either contact you later with more information or refer you to a resource person who can assist you.

I will assist you in understanding and organizing your Medicare bills and statements and help you develop a system to organize your Medicare-related paperwork yourself.

I will assist you in submitting claims for Medicare and supplemental insurance.

I will help you understand Medicare's appeals process and provide information to assist you in deciding whether you should file a Medicare appeal for Medicare decisions with which you disagree. If you are unable to pursue an appeal on your own, I can either assist you or refer you to the appropriate agency for assistance.

I will help you clarify the services that Medicare does not cover and help you evaluate your needs so you can make your own decision about buying a supplemental insurance policy. I can also show you how to compare specific policies so you can make your own decision on which one to purchase.

I will refer you to other resources and organizations in your community that can help you with Medicare-related problems that are complicated and should be addressed by a professional.

I will keep accurate notes about the counseling session and fill out a counseling report form.

WHAT COUNSELORS WILL NOT DO

I will not recommend that you purchase or terminate a specific insurance policy. Volunteer counselors do not sell, promote, or recommend any brand of insurance.

I will not share any information about your questions or problems with any other person or agency unless I am specifically authorized by you to do so. The only exception to this is the reporting to the Insurance Department for program assessment and recordkeeping. All contact with you will be strictly confidential.

I will not charge you for the counseling service that I provide as a volunteer counselor. This service is free to everyone. In some cases, I may ask you to pay for copying your bills or for postage if we must send information on your case to the insurance companies who administer Medicare or to your supplemental insurance company.

I will not make the final decision for you on any matter.

SECTION L
COMPREHENSIVE HEALTH ASSOCIATION OF NORTH DAKOTA
(CHAND)

The Comprehensive Health Association of North Dakota (CHAND) was created by the North Dakota Legislative Assembly in 1981 to provide comprehensive health insurance to residents of the state who had been denied health insurance or had been given restricted coverage because they had health problems and were considered to be in a high risk category. North Dakota is one of 29 states with risk pools available and was one of the first three in the country. Enrollment has grown from 78 contracts in 1982 to over 1,500 in 2002.

The program offers six coverage options: $500 and $1,000 deductibles with or without chiropractic endorsement and Medicare F supplement for over age 65 and under age 65 disabled. Only single policies are available and the lifetime maximum benefit a member can receive is $1,000,000, which is consistent with other risk plans. There is a coordination of benefit provision that makes CHAND secondary to all other third-party payors.

To be eligible for the program a person needs to have been a resident of North Dakota continuously for at least six months and have written evidence that at least one carrier has denied health care coverage or offered coverage which substantially restricts benefits for specific conditions.

CHAND has a 180-day waiting period for preexisting conditions except maternity, which has a 270-day waiting period. Waiting periods do not apply to members who are losing dependent status under a parent's or guardian's policy which has provided continuous coverage for the 12-month period immediately preceding the filing of the application nor does it apply to members who require non-elective treatment of a congenital or genetic disease. The legislation also includes a provision that authorizes the Board of Directors, by a two-thirds majority vote, to waive a waiting period under emergency circumstances to provide an applicant access to medical care deemed necessary to preserve life.

The 1997 Legislative Assembly passed legislation to implement the Health Insurance Portability and Accessibility Act (HIPAA) of 1996. As part of the federal Act, every state could either adopt an acceptable state alternative mechanism for group-to-individual portability or accept the federal "fall-back" mechanism. North Dakota opted to utilize CHAND as the alternative program. The waiting period of 180 consecutive days of coverage under this benefit plan may be reduced by days of membership under qualifying previous coverage, if continuous, to a date within 63 days prior to the effective date under this benefit plan. To qualify for CHAND as a HIPAA enrollee, the applicant must:

1. Be a current resident of this state; and

2. Have had 18 months of qualifying previous coverage, the most recent of which is coverage under a group health benefit plan, governmental, or church plan; and

3. Have applied for coverage within 63 days of the termination of the qualifying previous coverage; and

4. Not be eligible for coverage under a group health benefit plan, Medicare, or Medicaid; and

5. Not have any other health insurance coverage; and

6. Have not had prior coverage terminated for nonpayment of premiums or fraud; and

7. If offered the option, have elected continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under a similar state program and that coverage has been exhausted.

When days of membership under qualifying previous coverage are applied to the waiting period, benefits for covered services will be available to the extent provided by the coverage in force at the time covered services are received by the member. If no coverage is available for a specific service under the qualifying previous coverage, the waiting period will apply to the specific service.

In 2001 the Legislative Assembly passed an additional residency requirement for CHAND. It requires that an individual's CHAND coverage is terminated if a member physically resides out of the state of North Dakota for more than 182 days during any one benefit year.

The Board structure consists of one representative from each of the three largest premium volume accident and health companies, the Insurance Commissioner, the State Health Officer, the Director of the Office of Management and Budget, one senator and one representative.

The original legislation created a self-supporting pool through premium dollars; however, due to high claims costs, the original legislation was amended in 1983 to limit the cost of CHAND coverage to 135% of the average premium charged for standard coverage. All accident and health insurance companies who do a minimum of $100,000 of premium volume annually in North Dakota are required by law to participate in CHAND and contribute to its funding through an assessment that is based on their volume. The State of North Dakota subsidizes CHAND through premium tax credits equal to each company's

assessment. CHAND has also implemented several cost containment mechanisms, such as preadmission authorization, a prenatal program, and a concurrent review case management program to assist in controlling costs. Blue Cross Blue Shield of North Dakota is the current Lead Carrier for CHAND, providing administration of the day-to-day business of the pool.

A person who has been refused insurance coverage or has been told a significant health condition will be excluded from coverage may be eligible for CHAND. Contact any licensed health insurance agent for additional information. Only licensed agents may take an application. Any company denying or restricting coverage is required to inform the applicant about CHAND, the requirements for acceptance, and the procedure for applying.

The toll-fee number for CHAND is 1-800-737-0016.

SECTION M

GLOSSARY OF TERMS

GLOSSARY OF TERMS

Accelerated Death Benefit - Provision in a life insurance policy which permits an insured who is terminally ill to collect a fixed percentage of the death benefit before dying. This may be sold with the policy or as a rider to an existing policy. The object is to use the death benefit to pay health care expenses.

Activities of Daily Living (ADLs) - Activities which include help walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see "Custodial Care." An insured's inability to perform specific ADLs may qualify him or her for long-term care insurance benefits.

Actual Charge - The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare approved amount or amount approved by other insurance programs.

Acute Hospital - A hospital which provides care for persons who have a crisis, intense, or severe illness or condition which requires urgent restorative care.

Advance Beneficiary Notice (ABN) - A written notice (the standard government form CMS-R-131) received from physicians, providers, or suppliers before furnishing a service or item to notify the beneficiary:

- That Medicare will probably deny payment for that specific service or item.
- The reason the physician, provider, or supplier expects Medicare to deny payment.
- That the beneficiary will be personally and fully responsible for payment if Medicare denies payment.

An ABN gives the beneficiary the opportunity to refuse to receive the service or item.

Appeal (Medicare) - Medicare beneficiaries have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher review. See "Medicare Appeal."

Approved Charge (Allowable Charge) - The amount Medicare or other insurers will use as a basis for determining how much they will pay for a given service or piece of equipment. The Medicare approved charge is always the lowest of the customary, prevailing, or actual charge.

Area Agencies on Aging (AAA) - Local government agencies which grant or contract with public and private organizations to provide services for older persons within their area. In North Dakota, the Division of Aging Services of the Department of Human Services functions as the area agency on aging for the state. Call 1-800-274-2622 or 224-2577 from Bismarck-Mandan.

Assignment (Medicare) - The physician or supplier who "accepts assignment" under Medicare Part B agrees to accept Medicare's approved charge as payment in full. That means that after Medicare pays 80 percent of the approved amount, a doctor who accepts assignment can bill the patient (or the patient's insurance company) for only the additional 20 percent of the approved charge. See Section E.

Attained Age - The age you have reached. Insurance companies use this term when the policy's premium will increase as you grow older. The company will show prices for your "attained age".

Balance Billing - See "Excess Charges."

Beneficiary - Any person who receives benefits of an insurance policy or plan.

Benefit Maximum - The most a health insurance policy will pay for a specified loss or covered service. The benefit can be expressed as either:
a length of time (for example, 60 days), or
a dollar amount (for example, $350 for a specific procedure or illness), or
a percentage of the Medicare approved amount.
The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

Benefit Period - The time for which payments for benefits of an insurance policy are available. A single policy may include different benefit periods for different kinds of treatment or services.

Benefit Period (Medicare) - A benefit period under Medicare Part A begins when a patient enters a qualified hospital and does not end until the patient has been out of a hospital and not received Part A benefits for 60 consecutive days, including the day of discharge.

Benefit Trigger - The event that causes insurance benefits to start being paid.

Biological - Substances, such as whole blood, hemophilia clotting factors, tetanus antitoxins vaccines, tumor chemotherapy agent, etc.

Buy-In - Program in which the state's Medicaid program pays the Medicare premiums, deductibles, and copayments for certain low income eligible people.

Calendar Year - January 1 through December 31.

Carrier (Medicare) - Now called Medicare contractor.

Carve Out Retirement Plans - Plans that pay a specified plan benefit less what Medicare pays.

Centers for Medicare and Medicaid Services - A branch of the Department of Health and Human Services. The federal agency is responsible for administering the Medicare and Medicaid programs. It was formerly called Health Care Financing Administration (HCFA).

Certificate Holder - The person insured under a group insurance policy (see Group Insurance).

CHAMPUS - See TRICARE.

CHAND - Comprehensive Health Association of North Dakota - Created by the 1981 Legislative Assembly to provide comprehensive health insurance to residents of the state who had been denied health insurance or who had been given restricted coverage because they had health problems or were considered to be in a high risk category. See Section K.

Charges - Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

Chronic Condition - A continuous or prolonged illness or medical condition (example: asthma, diabetes, varicose veins).

Claim - A bill requesting that medical services be paid by Medicare or by some other insurance company.

Claim for Payment (CMS-1490S) - Called the Patient's Request for Medical Payment, this document is prepared by the beneficiary and submitted to the carrier for payment for covered services under Medicare Part B.

CMS - Centers for Medicare and Medicaid Services.

COBRA - Consolidated Omnibus Budget Reconciliation Act - Federal law requiring that workers who end employment for specified reasons have the option of purchasing group health insurance through the employer for a limited period (usually 18 months, but sometimes 36 months). When you purchase coverage under COBRA, you must pay the full premium including the employer's share.

Cognitive Impairment - Relates to mental ability to safely care for oneself.

Coinsurance or Copayment - A percentage or dollar amount of covered expenses which the beneficiary is required to pay.

Community Spouse - The spouse of an institutionalized spouse who is (1) not receiving Medicaid, and (2) not financially responsible for a child who is receiving Medicaid.

Conditionally Renewable - The company agrees to continue to insure you contingent upon certain specified conditions.

Conservatorship - A legal procedure by which one person (the conservator) is given power over the living arrangements, property and/or finances of another person (the conservatee). Conservatorships are established with legal safeguards for the conservatee.

Contractor (Medicare) - A private health insurance company under contract with the Centers for Medicare and Medicaid Services (CMS) to handle claims processing for Medicare Parts A and B. In North Dakota the contractor is Noridian Administrative Services.

Coordination of Benefits - Provisions and procedures used by insurers to avoid duplicate payments when a person is covered by more than one policy.

The primary payer is the policy which pays first--as if there were no other policies involved.

The secondary payer pays some or all of the balance.

The combined payments should not be more than 100 percent of the claim.

North Dakota's "coordination of benefits" law sets up rules for deciding which policy is "primary", but Medicare has its own special rules.

Coordination applies only to group plans and not individual coverage. Also see "Medicare as Second Payer".

Copayment (Coinsurance) - A specified dollar amount or percentage of covered expenses which an insurance policy or Medicare requires a beneficiary to pay towards medical bills. Medicare has two kinds of coinsurance:

Part A: Hospitalization coinsurance begins after the first 60 days in hospital, and the 21st through the 100th day of skilled nursing facility care.

Medicare Part B: Medical coinsurance is 20 percent of all Medicare approved charges.

Costs - Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same. Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

Covered Services - Services for which an insurance policy (or Medicare) will pay.

CPT ("Current Procedural Terminology") - A list of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on the "Request for Medicare Payment" form for claims submitted for Medicare payment (published by the American Medical Association--1990 Edition).

Custodial Care - Care intended primarily to meet personal needs and which could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living (ADLs).)

Customary Charge - The amount that individual physicians usually or frequently charge patients for specific services in similar medical circumstances.

Deductible - An initial amount of medical expense for which the beneficiary is responsible before Medicare or an insurance policy will pay.

DHHS - Department of Health and Human Services (federal).

Diagnostic Related Groups (DRGs) - A Medicare term for the system used to determine the amount that Medicare reimburses hospitals for inpatient services. DRG is part of the "Prospective Payment System". Medicare has divided categories of illnesses into 477 groups and assigns a DRG to each Medicare patient being admitted to a hospital. The hospital is reimbursed a fixed amount based on the patient's DRG code.

Disclosure Statements - A statement required by federal law which states the extent to which a policy duplicates Medicare.

Duplication of Coverage - Coverage of the same health services by more than one health insurance policy. Federal law prohibits duplication of Medicare supplement coverage.

Durable Medical Equipment (DME) - Durable medical equipment is equipment which can 1) withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally not useful to a person in the absence of an illness or injury, and 4) is appropriate for use in the home.

Durable Power of Attorney for Health Care - A legal document which authorizes another person to make decisions regarding your medical treatment only when you become incompetent. It cannot last longer than seven years and you can revoke it at any time.

Duration of Benefits - Time period or maximum amount of dollars for which an insurance policy will pay benefits.

Elimination Period - The number of days the insured must receive covered services before the insurance policy will begin paying. This is common in long-term care, hospital income, or indemnity type policies (also known as a deductible period).

End Stage Renal Disease (ESRD) - Medical condition in which a person's kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

Enrollment (Medicare) - Procedure by which eligible persons can sign up for the Medicare program and receive Medicare coverage. It is handled by the Social Security Administration through local Social Security offices. See Section C.

Enrollment Period - Period during which individuals may enroll for an insurance policy, Medicare, or health maintenance organization (HMO) benefits.

Entrance Age - The maximum or minimum age at which a company will sell the policy.

Excess Charges (Medicare) - The amount that a doctor's bill exceeds the Medicare-approved charge. Federal law limits this to 115 percent above the Medicare approved amount. Some Medicare supplement policies pay part or all of the excess charge. Also known as "balance billing". See Section E.

Exclusion - An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include preexisting conditions such as heart disease, diabetes, or hypertension. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for general conditions or the particular disease. Sometimes excluded conditions are excluded only for a defined period after coverage begins.

Expense Policy - A long-term care expense policy pays the actual daily charge up to a maximum daily benefit.

Experimental - Medical treatment which is not generally accepted within the medical profession. Insurance policies often do not cover "experimental" procedures, but companies and doctors often disagree as to whether a specified procedure or treatment is experimental.

Explanation of Medicare Benefits (EOMB) Forms - This has been replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly.

Fee for Service - Method of charging whereby a physician or other practitioner bills for each encounter (visit) or service rendered. This is the way most doctors bill.

Fee Schedule - A listing of accepted charges or established allowances for specified medical, dental, or other procedures or services. The fee schedule usually represents either a physician's or third party's standard or maximum charges for the listed procedures.

Fiscal Year (FY) - The federal government's budget (or fiscal) year runs from October 1 to September 30 of the following calendar year.

Free Look - The period during which you may reconsider the purchase of an insurance policy, cancel, and get a full refund. Medicare supplement and long-term care policies have a 30-day "free look".

General Enrollment Period - An annual enrollment opportunity from January 1 through March 31 for anyone who did not sign up for Part B of Medicare during the initial enrollment period.

Grace Period - A specified period after a premium payment is due on an insurance policy in which the policyholder may make such payment and during which the provisions of the policy continue, usually 30 days.

Grievance - A complaint about the way a Medicare health plan is giving care. One may chose to file a grievance, for example, if problems are experienced with cleanliness of a facility, contacting the plan, staff behavior, or operating hours.

Group Insurance - A group policy is a written contract between an insurer and a "middle man", usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance stating the provisions of the coverage given to each insured individual or family.

Guaranteed Issue - An insurance policy which will be issued to anyone, regardless of health.

Guaranteed Issue Rights - Rights available in certain situations to a beneficiary when insurance companies are required by law to issue a Medigap policy.

Guaranteed Renewable - The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The company cannot change benefits or increase premiums because you have made claims. However, the insurance company can raise the premiums for all policyholders based on their experience.

Health and Human Services, Department of - An executive department of the federal government which has the ultimate authority for the Medicare and Medicaid programs.

Health Care Financing Administration (HCFA) - The former name for what is now called Centers for Medicare and Medicaid Services.

Health Insurance Claim Number (HIC) - The unique alphanumeric Medicare entitlement number assigned to a Medicare beneficiary. The number is generally the Social Security number and will appear on the Medicare card.

Health Maintenance Organization (HMO) - An organization that provides a comprehensive range of health services (including hospitalization, preventive care, diagnosis, and nursing). HMOs require members to use specific health care services (doctors, hospitals, etc.) which belong to the HMOs "network". The HMO will pay less or nothing if members go outside the network.

Home Health Agency - A public or private agency that specializes in providing skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Aide - A semi-skilled professional, often employed by a home health agency, who provides in-home assistance with activities of daily living.

Home Health Care - Health care services provided in the home on a part-time basis for the treatment of an illness or injury. Medicare pays for home care only if:
The patient needs skilled care; and
Care is required on an intermittent basis; and
Care is intended to help the patient recover or improve from an illness.

Hospice - A public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families. Hospice services may be received at home or in a hospice facility. Medicare covers most hospice care.

Inflation Protection Feature - Feature which provides for an automatic benefit increase each year (generally five percent a year for the first 10 years) in order to protect against the rising costs of long-term care insurance.

Illegal Sales Practices - Sales techniques used by insurance agents selling health insurance to supplement Medicare (Medigap) in which they mislead older adults into buying unnecessary coverage or paying premiums for no coverage.

Indemnity Policy - Type of insurance policy which pays a fixed amount per day for covered services received.

Individual Health Insurance - A written contract between an insurance company and an insured person (contrast with "group" health insurance).

In-Home Supportive Services (IHSS) - Personal care services and nonmedical services to help functionally impaired persons of all ages with limited resources stay at home. It is paid for qualifying persons by Title XX of the Social Security Act.

Initial Enrollment Period (Medicare) - The seven months surrounding a person's 65th birth month which is the best time to enroll for Medicare.

Inpatient - A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services.

Institutional Spouse - An individual who (1) is in a swing bed, State Hospital, or nursing facility and at the beginning of the institutionalization was unlikely to be in the facility for at least 30 consecutive days (even if the individual does not actually remain in the facility for 30 consecutive days), and (2) is married to a spouse who is not in a swing bed, State Hospital, or nursing facility.

Institutionalization - Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period of time or indefinitely.

Insured - The individual or organization protected by an insurance policy.

Insurer - A company which contracts to reimburse the insured for a loss covered by an insurance policy.

Intermediary or Fiscal Intermediary (FI) - Now called Medicare contractor.

Issue Age - A term used by insurance companies meaning the age you were when you purchased the policy.

Length of Stay - The time a patient stays in a hospital or other health facility.

Lifetime Maximum - The maximum dollar amount that a policy will pay in the policyholder's lifetime.

Lifetime Reserve (Medicare) - Under Medicare Part A, the "lifetime reserve" days begin after the patient has been in the hospital for 90 days in a single benefit period. Medicare pays only part of the cost for a total of 60 lifetime reserve days.

Limited Benefit Plans - Insurance plans that generally offer low premiums for limited coverage of a specific event.

Loading Up - Selling two or more health insurance policies when one is adequate. It is usually the result of unscrupulous sales practices. Also called "stacking."

Long-Term Care (LTC) - The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long term care can be provided:

At home, by family members assisted with voluntary or employed help (such as provided by home health care agencies).

In adult day health care centers.

In institutions (nursing homes).

Long-Term Care Insurance - A policy designed to help pay the costs of long-term care. Benefits are often paid in the form of a fixed dollar amount (per day or per visit) for covered long-term care expenses and may exclude or limit certain conditions from coverage. See Section H.

Long-Term Care Ombudsman - The office responsible for investigating patient complaints about long-term care facilities. In North Dakota, ombudsman services are available through the Aging Services Division of the Department of Human Services. To reach the ombudsman, call toll-free 1-800-472-2622 or 224-2577 in Bismarck-Mandan.

Loss - The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Loss Ratio - The amount that an insurer has paid for claims (loss) compared to the amount it collected from all customers in premiums, usually shown as a percentage. For example, Medicare supplement policies must have a loss ratio of at least 65 percent, which means the company must pay out 65 cents for every dollar it collects over an established timeframe.

Mammogram - The x-ray of the breast to diagnose breast cancer.

Medically Necessary - Physician's determination that specific treatment is required. Medicare and insurance policies typically will pay only for services which are "medically necessary". Unfortunately, Medicare or your insurance company may not always agree with your doctor's opinion.

Medicare - Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some disabled persons under 65. Medicare has two parts:

Part A is hospital insurance and primarily provides coverage for inpatient care.

Part B is medical insurance and provides limited coverage for physician services and supplies for the diagnosis and treatment of illness or injury.

Medicare Advantage - A Medicare program that provides more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease. Previously referred to as Medicare+Choice.

Medicare Advantage Plan - A health plan, such as a Medicare managed care plan or private fee-for-service plan offered by a private company and approved by Medicare. An alternative to the original Medicare plan. Previously referred to as Medicare+Choice plan.

Medicare Appeal - Procedure by which a beneficiary who disagrees with the amount of Medicare Part B reimbursement can challenge the Medicare carrier.

Must file appeal within six months of the date of the EOMB.

Within 60 days of an unsatisfactory decision for an amount over $100, a beneficiary may request a hearing by an administrative law judge.

Medicare Part A appeals have different deadlines and limits on appealable amounts.

Medicare Benefit Notice - The form a Medicare beneficiary receives from the Medicare intermediary explaining Part A benefits used and the status of deductible and coinsurance.

Medicare+Choice - Now called Medicare Advantage.

Medicare+Choice Plan - Now called Medicare Advantage Plan.

Medicare Contractor - A private health insurance company under contract with the Centers for Medicare and Medicaid Services (CMS) to handle claims processing for Medicare Parts A and B. In North Dakota the contractor is Noridian Administrative Services.

Medicare Modernization Act - See Medicare Prescription Drug Improvement and Modernization Act of 2003.

Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) - The federal signed into law December 8, 2003, by President Bush. The Act is perhaps the most significant change to Medicare since Medicare was established in 1965. The law provided the first comprehensive prescription drug benefit, as well as other changes.

Medicare Select - A Medicare supplement policy which offers a lower premium if you use specific doctors, hospitals, and other providers. Similar to a health maintenance organization (HMO).

Medicare as Secondary Payer - Situations where you are covered by another plan in addition to Medicare and the law requires that plan to pay first. Medicare may be secondary when you are covered by a group plan and:

You or your spouse continue to work.
You are disabled and under 65.
You are covered by workers' compensation or similar benefits.

Medicare Summary Notice (MSN) - A statement that lists the beneficiary's health insurance claims information. It replaces the Explanation of your Medicare Part B Benefits (EOMB), the Medicare Benefit Notice (Part A), the Explanation of Medicare Benefits (Part A), and Benefit Denial letters. It lists all the services or supplies that were billed to Medicare for a 30-day period of time. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the beneficiary must pay. It is important to check this notice to be sure the beneficiary got all the services, medical supplies, or equipment that providers billed to Medicare. If there are any questions, a telephone number is listed in the Customer Service Information box on the front of the MSN. If there are disagreements with a claims decision, instructions on how to file an appeal are on the MSN.

Medicare Supplemental Policy (Medigap, MedSup) - Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and copayment). See Section F.

Medigap - Same as Medicare supplement policy.

MEDPARD - Medicare Participating Physicians and Suppliers Directory. Directory issued by a carrier listing all physicians in that carrier's area who accept Medicare assignment.

National Association of Insurance Commissioners (NAIC) - An organization made up of all of the nation's state insurance departments. The NAIC writes model laws and regulations for insurance companies and state legislatures.

No Age Rating - A term used by insurance companies in which premium is the same for all customers regardless of age.

Noncancellable - Refers to a set premium rate. Policies/certificates with a noncancellable premium guarantee the insured the right to continue the policy for a specific period of time and also guarantee the premium rate during that period.

Nonforfeiture - An optional feature of some insurance policies (usually long-term care insurance) that provides for some benefits to be paid if certain conditions have been met and the policy is lapsed. See Section H.

Nonparticipating Facility or Physician - Health care facility which does not participate in the Medicare program.

Notice of Non-Coverage (Medicare) - Notice from a hospital that a Medicare patient no longer requires inpatient hospital care. See Section D.

If you continue to stay in the hospital, you become liable for all expenses starting three days after the notice.

Medicare beneficiaries can appeal through an expedited appeal to the peer review organization or through the usual Medicare Part A appeals procedure.

Nursing Home - A place where persons reside who need medical or personal assistance. A nursing home can provide up to three levels of care: skilled, intermediate, and custodial. Not all nursing homes are Medicare approved/certified facilities.

Nursing Home Policy - Health insurance policy which generally pays daily benefits, e.g., $80 per day, for medically necessary stays in nursing home (sometimes referred to as long-term care policies).

Occupational Therapy - Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

Older Americans Act (OAA) - Federal legislation enacted in 1965 to provide money for programs and direction for a multitude of services designed to enrich the lives of senior citizens (for example, adequate housing, income, employment, nutrition, and health care).

Ombudsman - A "citizens' representative" who protects a person's rights through advocacy, providing information, and encouraging institutions or agencies to respect citizens' rights.

Open Enrollment - A period when new subscribers may elect to enroll in a health insurance plan or HMO.

During open enrollment the HMO cannot reject applications because of bad health.

You are not eligible for open enrollment as long as you are eligible to be covered by an employer's health plan.

Open Enrollment (Medicare Supplement) - The six-month period during which a new Medicare beneficiary can buy Medicare supplement insurance regardless of health problems.
- Open enrollment begins when a person 65 or over signs up for Medicare Part B.
- During your six-month long open enrollment period, an insurance company must sell you any coverage it offers, regardless of your health.
- After open enrollment, the company can reject your application because of you health or age.

Out-of-Pocket Expenses - Costs borne directly by the patient without benefit of insurance; direct costs.

Outlier Case (Medicare) - An unusual medical situation which requires longer hospital stays or higher treatment costs than Medicare would ordinarily cover. Once Medicare has ruled that it is an "outlier case," Medicare will pay the expenses.

Outpatient - A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

Participating Facility or Physician - Health care provider which participates in the Medicare program and accepts Medicare payment for services. The participating provider accepts the Medicare-approved amount as payment in full. (NOTE: The patient must still pay copayments and deductibles if not covered by insurance.)

Participating Physicians/Supplier Agreement - An agreement, by an individual physician or supplier, to accept the Medicare approved amount as payment in full for all Medicare beneficiaries served. This agreement is valid for the calendar year and may be renewed annually. Always use a current MEDPARD (Medicare Participating Physicians Directory) when looking for a participating physician or call 1-800-247-2267.

Peer Review Organization (PRO) - Organization paid by the federal government to review hospital treatment of Medicare patients. A patient has the right to appeal to a PRO if there is a question about care or length of stay.

Personal Care - Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming, or personal hygiene. These services are not routinely paid for by either Medicare or Medicaid, but for those who qualify may be paid for by in-home supportive services (IHSS).

Personal Comfort Items - For inpatients in a hospital, such items as a television, telephone, etc.

Physical Therapy - Services provided by specially trained and licensed physical therapists in order to relieve pain, restore maximum function, and prevent disability, injury, or loss of body part.

Physician Payment Reform - A 1990 law which limits the amount doctors can charge Medicare patients. It also requires doctors to file Medicare claims for their patients.

Physician Limiting Charge - The maximum amount Medicare allows a nonparticipating doctor to charge for a particular service. See Section E.

Power of Attorney - A legal document which gives a person (usually a spouse, other relative, or friend) the power to act on behalf of another. The person giving the power must be competent and does not lose the legal right to act on his own behalf.

Preexisting Condition - Health conditions or problems that existed before health insurance was purchased. The definition and waiting period before these conditions are covered vary from policy to policy.

Medicare supplement policies define "pre-ex" as a condition for which you received medical advice or treatment in the six months before you bought the policy.

Some insurance policies (including many long-term care policies) do not cover any condition which was "in existence" during the previous 6-12 months, even if you were not aware of it or were not treated for it.

Preferred Provider Organization (PPO) - Health service plan with a network of physicians and suppliers who provide services to the plan's participants at agreed prices. The PPO may also offer additional benefits such as discounts on prescription drugs, transportation discounts, and access to health education programs.

Premium - Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder for insurance coverage.

Precertification (Prior Authorization) - A requirement that you obtain the insurance company's approval before a medical service is provided. If you fail to follow the precertification procedures, the company may reduce or deny claim payment. The provider generally will contact the insurance company on your behalf to explain what treatment is needed and request precertification. Precertification verifies coverage but does not guarantee claim payment.

Primary Payer - Insurer that pays first when a person is covered by more than one insurance plan. See "Secondary Payer and Coordination of Benefits."

Private Fee-for-Service Plan - One of the Medicare Advantage plans. It allows the enrollee to use any Medicare-approved provider that accepts the plan’s terms and conditions.

Prospective Payment System (PPS) - Medicare's standardized payment system developed to help control health care costs. The PPS is supposed to discourage hospitals from providing unnecessary care. Medicare pays fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases, the Medicare payment will be more than the actual cost of providing service for that stay. In other cases, the payment will be less than the hospital's actual cost. Also see "Outlier Cases."

Provider - Someone who provides medical services or supplies, such as a physician, hospital, x-ray company, home health agency, or pharmacy.

Qualified Medicare Beneficiaries (QMBs) - A state program that uses Medicaid money to pay the Medicare deductibles, insurance, and the Medicare Part B premium for persons whose income and assets are low enough to qualify. Persons who believe they may be eligible should contact their local county Social Service Office.

Railroad Retirement System - Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare).

Reasonable Charge - See "Approved Charge."

Reasonable and Necessary Care - The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Reconsideration (Medicare) - The first step in the Medicare Part A appeal process. The beneficiary sends a written request to the intermediary disagreeing with the Part A payment and asking that the payment decision be reviewed.

Replacement Notice - Form that agent/company and buyer must sign when switching from one Medicare supplement policy to another. Protects consumers against frivolous policy switching.

Respite Care - Services designed to provide temporary relief to a home caregiver. Example: Mrs. Jones has been taking care of her sick husband. She needs a break! An insurance policy (long-term care) with "respite care" could cover the cost of a temporary substitute.

Review (Medicare) - The first step in the Medicare Part B appeal process in which the beneficiary sends a written request to the carrier showing his or her disagreement with the Part B payment allowed for a claim and asking that the payment decision be reviewed.

Rider - A legal document which modifies an insurance policy. Riders may either extend or decrease benefits or add or exclude specific conditions.

Secondary Payer - Only applies when a person is covered by more than one health plan. The secondary payer is the plan whose payments cannot be made until another plan (the primary payer) has processed the claim. See "Coordination of Benefits."

Self-Insured Plan - An organization (usually an employer) which provides group health benefits which are not covered by an insurance company. Many large employers are self-insured. The organization must pay all health claims from its own funds.

Service Benefits - Type of benefits which pays the costs of the services covered by the policy rather than a fixed dollar amount.

Skilled Nursing Care - Care which can only be provided by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility - A Medicare-approved skilled nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services, and other important related health services for which Medicare pays benefits.

Social Security Administration (SSA) - A branch of the Department of Health and Human Services. This federal agency is responsible for the Medicare eligibility and enrollment process.

Special Enrollment Period - Enrollment opportunity for people who continue to work past age 65 and are covered by an employer group health plan, or those who are retired but covered by a spouse's employer group health plan.

Specific Disease Policy - Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance. See Section G.

Speech Therapy - The study, examination, and treatment of defects and diseases of the voice, speech, spoken, and written language.

Spend Down (Medicaid) - Process by which a person becomes eligible for Medicare by becoming poor--for example, through paying nursing home bills.

Spousal Impoverishment (Medicaid) - The community property and assets of a married nursing home patient may be divided according to HCFA standards to protect the property and assets of the spouse.

Stacking - Unscrupulous insurance sales practice. Selling two or more health insurance policies to a person when one is adequate. Stacking is illegal when selling Medicare supplement insurance.

Standardization of Medicare Supplement - Beginning in 1992, Medicare supplement policies must be identical to one of 10 standard plans. See Section F.

Suitability - Obligation of insurance agent to sell policies to consumers which are appropriate purchases given the circumstances of the purchaser.

Supplemental Security Income (SSI) - A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is or blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

Suppliers - Persons or organizations, other than physicians or health care facilities, that furnish medical equipment or services, such as ambulance firms, laboratories, and equipment rental outlets.

Swing Beds - Rural hospitals with fewer than 99 beds may enter into "swing bed agreements which allow them to use beds for either acute (hospital) or long-term (skilled nursing) care beds depending on the patient's needs.

Third Party Liability (Medicare) - The responsibility of a person other than a beneficiary to pay part or all of a specific Medicare claim. Example: A Medicare supplement policy has "third-party liability."

Title XVIII - That portion of the Social Security Act which clearly defines the provisions of Medicare.

Title XIX - That portion of the Social Security Act which clearly defines the provisions of Medicaid.

TRICARE - The health care program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was called CHAMPUS in the past.

Twisting - The unscrupulous insurance sales practice of replacing an existing health insurance policy with a new one from a different company in order to receive the high first-year sales commission. NOTE: This is illegal when selling Medicare supplement insurance. When replacing a Medicare supplement policy, the agent is never entitled to a first-year commission.

Unassigned Claim - A claim on which the doctor or supplier refuses to accept Medicare's approved charge. See Section E.

Underwriting - The process by which an insurer establishes and assumes risks according to insurability. Example: An insurance company is "underwriting" when it agrees to insure you because you are healthy or rejects your application because you have a history of heart attacks.

Usual and Prevailing Charge (Medicare) - This means the normal charge made by the provider for a service or supply, but not more than the general level of charges made in the area for similar service or supplies. The "usual and prevailing" charge is not necessarily the doctor's actual charge.

Usual, Customary, and Reasonable Charge (UCR) - In "insurance language" this is the amount the company has determined to be appropriate for a particular medical service. Each company develops its own UCR. A company's UCR is often less than doctors actually charge.

Utilization Review Committee - Committee in a health care facility which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices.

VA - Veterans' Administration (federal).

Visit - An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional's usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient's home. Doctors' services can be covered in any of these settings under Medicare.

Waiting Period - The period of time that must pass after becoming insured before the policy will begin to pay benefits for a preexisting condition or certain specified illness.

Waiver of Liability - Occurs when Medicare denies coverage of a Medicare benefit and the beneficiary did not know and did not have reason to know that Medicare would deny the coverage.

Waiver of Premium - A potential feature of a long-term care insurance plan. Premium payments are not required when the beneficiary is confined and receiving benefits. The policy/certificate will indicate when the waiver will begin. The waiver ends when confinement ends. See Section H.

ACRONYMS

ADL - Activities of Daily Living

AFDC - Aid to Families With Dependent Children

CHAND - Comprehensive Health Association of North Dakota

CMS - Centers for Medicare and Medicaid Services

COBRA - Consolidated Omnibus Budget Reconciliation Act

CPT - Current Procedural Terminology

DHHS - Department of Health and Human Services

DRG - Diagnostic Related Group

DME - Durable Medical Equipment

ESRD - End Stage Renal Disease

EOMB - Explanation of Medicare Benefits

FY - Fiscal Year

HCFA - Health Care Financing Administration - now called CMS (Centers for Medicare and Medicaid Services)

HIC - Health Insurance Claim

HIPP - Health Insurance Premium Payment

HMO - Health Maintenance Organization

IHSS - In-Home Supportive Services

FI - Fiscal Intermediary

ICF - Intermediate Care Facility

LTC - Long-Term Care Insurance

MA - Medicare Advantage

MEDPARD - Medicare Participating Physicians and Supplier Directory

MEDSUP - Medicare Supplement Insurance

MMA - Medicare Modernization Act

NAIC - National Association of Insurance Commissioners

OAA - Older American Act

OBRA '90 - Omnibus Budget Reconciliation Act of 1990

PRO - Peer Review Organization

PPO - Preferred Provider Organization

PPS - Prospective Payment System

QMB - Qualified Medicare Beneficiary

SHIC - Senior Health Insurance Counseling Program

SLMB - Special Low-Income Medicare Beneficiary

SNF - Skilled Nursing Facility

SPED - Service Payments for the Elderly and Disabled

SSA - Social Security Administration

SSN - Social Security Number

SSI - Supplemental Security Income

TBI - Traumatic Brain Injured Waiver

UCR - Usual, Customary, and Reasonable

SECTION N

RESOURCE AND REFERRAL

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RESOURCE/REFERRAL TELEPHONE NUMBERS

Aging Services Division
Department of Human Services
State Capitol
600 East Boulevard Ave., Dept. 325
Bismarck, ND 58505-0250
Toll-free: 1-800-755-8521
Local: 328-4601
Fax: 328-4061

Department of Insurance
State Capitol
600 East Boulevard Ave., Dept. 401
Bismarck, ND 58505-0320
Toll-free: 1-800-247-0560
Local: 328-2440
Fax: 328-4880
Web Site: www.state.nd.us/ndins

Assistive Technology Help-Line 1-800-472-2911

CHAND (Section L) 1-800-737-0016

CIGNA Medicare (DME Carrier) 1-800-633-4227
P.O. Box 690
Nashville, TN 37202
www.CignaMedicare.com

County Social Service Offices . . . . . See Page N-6

Government Benefit Administrators (Home Health/Hospice Carrier) . . 1-800-633-4227
Medicare Part A Claims
1201 Zenith Drive, Suite 100
Sioux City, IA 51103-5217

Coordination of Benefits Contractor 1-800-999-1118

CMS Fraud Hotline 1-800-447-8477

Medicare Phone Appeals 1-800-279-5331

Legal Services of North Dakota . . . . . See Page N-19

Medicare Maze Masters Project 1-877-258-5263

Long Term Care Ombudsman (Helen Funk) 1-800-451-8693

Medicare Operations Center (Carrier/Intermediary) 1-800-633-4227
4305 13th Avenue SW
Fargo, ND 58103-3309
www.noridianmedicare.com

ND Association for the Disabled . . . . . Toll-free: 1-800-532-6323

Regional Aging Services Coordinators . . . . . See Page N-5

Social Security Administration . . . . . See Page N-7

ND Health Care Review, Inc. (QIO) 1-800-472-2902
800 31st Avenue SW . . . . . Local: 1-701-852-4231
Minot, ND 58701
www.ndhcri.org

Senior Info-Line (Resource and Referral Service) 1-800-451-8693
Aging Services Division . . . . . Local: 1-701-328-4601
Department of Human Services
State Capitol
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

Veterans Affairs 1-800-827-1000
County Offices . . . . . See Page N-8
Bismarck Office 1-701-328-5465
Main Office: 1-701-239-7165
1411 32nd Street South
Fargo, ND 58106-9003

HELPFUL WEBSITES

www.medicare.gov	The federal government's official Medicare site. The website offers basic information about Medicare, fraud and abuse, information on how to stay healthy, publications to view and download, helpful contacts, tips on choosing a nursing home, prescription drug plans, and Medicare supplement policies as well as local Medicare plan choices.
www.medicarerights.org	The Medicare Rights Center (MRC) is a not-for-profit organization. MRC works to ensure that beneficiaries get good health care that is affordable and offers information about Medicare coverage. The site provides email answers to Medicare questions, access to educational materials, and links to related sites.
www.CignaMedicare.com	(DME carrier) This site offers publications to view and download, an online help center, beneficiary resources and helpful links, supplier resources and an email notification service.
www.cms.hhs.gov	The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and CLIA.
www.accesstobenefits.com	The Access to Benefits Coalition™ (ABC) is dedicated to assisting Medicare beneficiaries, especially those who need help the most, to find prescription savings programs that could save them hundreds or even thousands of dollars every year.
www.shiptalk.org	The State Health Insurance Assistance Program, or SHIP, is a national program that offers one-on-one counseling and assistance to people with Medicare and their families. Through grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.

	At this site you can access the SHIP profiles for each state. Click on the tab labeled "State Profiles" near the top of the screen. You may then choose which state's information you wish to display.
www.govbenefits.gov	GovBenefits.gov is a free and confidential prescreening tool. Search for federal, state, or other benefits that you may be eligible to receive.
www.rxconnectnd.org www.rxassist.org www.needymeds.com www.destinationrx.com	Provides the information needed to access patient assistance programs for free, or for discounted drugs, that are offered through many pharmaceutical manufacturers for low-income patients without prescription insurance.
www.disabilityinfo.gov	This easy-to-use web portal is a directory of government web links relevant to people with disabilities, their families, employers, service providers, and other community members.
www.rxoutreach.com	Rx Outreach is a new Patient Assistance Program that provides qualified low-income individuals and families with access to generic versions of brand name medications. Generic medications are not currently available through other Patient Assistance Programs.
www.opm.gov/insure	The website is designed to help federal employees understand their health plan options.
www.dol.gov/dol/elaws	U.S. Department of Labor, Pension and Welfare Benefits Administration Division. This federal agency provides oversight to self-insured plans exempt from state insurance department regulation, including employer retiree health benefit plans. The site provides information on COBRA, Health Care Bill of Rights, and HIPAA.
www.state.nd.us/ndins	This site provides access to SHIC sponsor sites in North Dakota as well as the Medicare supplement premium comparison.

REGIONAL AGING SERVICES ADMINISTRATORS

Badlands Human Service Center
Mark Jesser, RASPA
200 Pulver Hall
Dickinson, ND 58601-4857

Lake Region Human Service Center
Donna Olson, RASPA
200 Highway 2 SW
Devils Lake, ND 58301-3595

North Central Human Service Center
MariDon Sorum, RASPA
400 22nd Avenue NW
Minot, ND 58703

Northeast Human Service Center
Patricia Soli, RASPA
151 South 4th Street, Suite 401
Grand Forks, ND 58201-4735

Northwest Human Service Center
Karen Quick, RASPA
316 2nd Avenue West
Williston, ND 58802-1266

South Central Human Service Center
Russ Sunderland, RASPA
520 3rd Street NW
Jamestown, ND 58402

Southeast Human Service Center
Sandy Arends, RASPA
2624 9th Avenue
Fargo, ND 58103-2350

West Central Human Service Center
Cherry Schmidt, RASPA
600 South 2nd Street, Suite 5
Bismarck, ND 58504-5731

COUNTY SOCIAL SERVICE BOARD DIRECTORY

Co. #	County Location	County Director	UPS and FedEx Address	Postal Address	City, State, Zip	Phone	Fax	TTY	E-Mail Address
1	Adams	Richard Fedje	606 2nd Avenue N.	PO Box 550	Hettinger, ND 58639	567-2967	567-4799		17fedn@state.nd.us
2	Barnes	Heather Pautz	230 4th St NW Rm 105		Valley City, ND 58072-2994	845-8521	845-4281		02pauh@state.nd.us
3	Benson	Edward D. Forde	108 4th St East	PO Box 186	Minnewaukan, ND 58351	473-5302	473-5330	662-7088	36fore@state.nd.us
4	Billings	Richard Fedje	67 1st Street SE	PO Box 279	Beach, ND 58621-0279	872-4121/4122	872-3141		17fedr@state.nd.us
5	Bottineau	Mary Rothmann	314 W 5th Street		Bottineau, ND 58318	228-3613	228-3600		05rotm@state.nd.us
6	Bowman	Janice Burk	104 West 1st	PO Box 469	Bowman, ND 58623	523-3285	523-5871		06burj@state.nd.us
7	Burke	Bryan Quigley	103 Main Street SE	PO Box 220	Bowbells, ND 58721	377-2313	377-2302	377-2318	07quib@state.nd.us
8	Burleigh	Shari Doe	415 E Rosser Ave Ste 113		Bismarck, ND 58501-4058	222-6622	222-6644/6476	222-6622	08does@state.nd.us
9	Cass	Kathy Hogan	1010 2nd Avenue South	PO Box 2986	Fargo, ND 58108-2986	241-5761	239-6820	239-6784	09hogk@state.nd.us
10	Cavalier	Melody King	324 7th Avenue	PO Box 630	Langdon, ND 58249	256-2175	256-2179	256-2311	34kinm@state.nd.us
11	Dickey	Robert Carlson	205 15th Street North	PO Box 279	Ellendale, ND 58436	349-3271	349-3277	349-3215	11carr@state.nd.us
12	Divide	Gloria McKamey	300 2nd Avenue N.	PO Box 9	Crosby, ND 58730-0009	965-6521	965-6529		12mckg@state.nd.us
13	Dunn	Thomas Picken	215 Central Street	P.O. Box 89	Killdeer, ND 58640	764-5385	764-5070		13pict@state.nd.us
14	Eddy	John Mogren	22 9th Street South		New Rockford, ND 58356	947-5314	947-2960	947-5003	52mogj@state.nd.us
15	Emmons	Klaes Welch	100 NW 4th Street	PO Box 726	Linton, ND 58552	254-4502	254-4503		15welk@state.nd.us
16	Foster	John Mogren	1000 N. Central Avenue	PO Box 80	Carrington, ND 58421	652-2221	652-2207		52mogj@state.nd.us
17	Golden Valley	Richard Fedje	67 1st Street SE	PO Box 279	Beach, ND 58621-0279	872-4121/4122	872-3141		17fedr@state.nd.us
18	Grand Forks	Keith Berger	151 S 4th St Suite 200	PO Box 5196	Grand Forks, ND 58206-5196	787-8535	772-1426		18berk@state.nd.us
19	Grant	Iola Ruscheinsky	106 2nd Avenue NE	PO Box 278	Carson, ND 58529	622-3706	622-3045		19rusi@state.nd.us
20	Griggs	Marcia Beglau	808 Rollin Ave SW	PO Box 567	Cooperstown, ND 58425	797-2127	797-2172		20begm@state.nd.us
21	Hettinger	Douglas Wegh	309 Millionaire Avenue	PO Box 228, RR 1	Mott, ND 58646	824-3276	824-2820	824-2820	21wegd@state.nd.us
22	Kidder	Deb Abbott	120 East Broadway	PO Box 36	Steele, ND 58482	475-2551	475-2298	475-2551	22abbd@state.nd.us
23	LaMoure	Robert Carlson	202 4th Avenue NE	PO Box 38	LaMoure, ND 58458	883-5301/ext 7	883-4244		11carr@state.nd.us
24	Logan	Maria Regner	301 Broadway		Napoleon, ND 58561-7010	754-2283	754-2282	754-2283	24janl@state.nd.us
25	McHenry	Winston Pottenger	407 S. Main	PO Box 58	Towner, ND 58788	537-5944	537-5417		35potw@state.nd.us
26	McIntosh	Klaes Welch	112 NE 1st Street	PO Box 218	Ashley, ND 58413	288-3343	288-2186		15welk@state.nd.us
27	McKenzie	Michon Sax	201 Northwest 5th	PO Box 790	Watford City, ND 58854	444-3661	444-6436		53saxm@state.nd.us
28	McLean	Roger Redfield	712 5th Avenue	PO Box 70	Washburn, ND 58577	462-3235	462-8131		28redr@state.nd.us
29	Mercer	Roger Redfield	1030 Arthur Street	PO Box 70	Stanton, ND 58571	745-3384	745-3390		28redr@state.nd.us
30	Morton	Kenneth Gerhardt	200 2nd Avenue NW		Mandan, ND 58554-3124	667-3395	667-3384	667-3380	30gerk@state.nd.us
31	Mountrail	Bryan Quigley	18 2nd Avenue SE	PO Box 39	Stanley, ND 58784-0039	628-2925	628-3175		31quib@state.nd.us
32	Nelson	Dawn Haugen	210 B Avenue W, Ste 301		Lakota, ND 58344-7410	247-2945	247-2943		32haud@state.nd.us
33	Oliver	Roger Redfield		PO Box 145	Center, ND 58530	794-3212	794-3476		33redr@state.nd.us
34	Pembina	Melody King	300 Boundary Rd W #3		Cavalier, ND 58220	265-8441	265-8058		34kinm@state.nd.us
35	Pierce	Winston Pottenger	820 South Main Avenue		Rugby, ND 58368	776-5818	776-2516	776-5818	35potw@state.nd.us
36	Ramsey	Edward D. Forde	524 4th Avenue #19		Devils Lake, ND 58301-2400	662-7050	662-7095	662-7088	36fore@state.nd.us
37	Ransom	Wendy Jacobson	205 4th Avenue W.	PO Box 628	Lisbon, ND 58054-0628	683-5661	683-4491		41jacw@state.nd.us
38	Renville	Terry Alexander	217 Main Street East	PO Box 305	Mohall, ND 58761-0305	756-6374	756-7158	756-6386	38alet@state.nd.us
39	Richland	Kristen Hasbargen	413 3rd Avenue North		Wahpeton, ND 58075	642-7751	642-7826	642-7778	39klip@state.nd.us
40	Rolette	Beverly Mathiason	212 2nd Avenue NE	PO Box 519	Rolla, ND 58367	477-3141	477-5979	477-8711	40matb@state.nd.us
41	Sargent	Wendy Jacobson	355 Main Street	PO Box 156	Forman, ND 58032-0156	724-6241 ext 7	724-3323	724-3302	41jacw@state.nd.us
42	Sheridan	Roger Redfield	215 E. 2nd Street	PO Box 440	McClusky, ND 58463	363-2281	363-2702		28redr@state.nd.us
43	Sioux	Vince Gillette	303 2nd Avenue	PO Box B	Fort Yates, ND 58538	854-3821	854-3854		43gilv@state.nd.us
44	Slope	Janice Burk	104 West 1st	PO Box 469	Bowman, ND 58623	523-3285	523-5871		06burj@state.nd.us
45	Stark	Larry Bernhardt	664 12th Street West		Dickinson, ND 58601	456-7675	456-7777		45berl@state.nd.us
46	Steele	Stephen Dahl	600 S Washington Ave	PO Box 276	Finley, ND 58230	524-2584	524-1103	524-2060	46dahs@state.nd.us
47	Stutsman	Clarence Daniel	116 1st Street E.	PO Box 809	Jamestown, ND 58402-0809	252-7172	252-1561	252-7172	47danc@state.nd.us
48	Towner	Edward Forde	315 2nd Street	PO Box 604	Cando, ND 58324	968-4355 ext 8	968-4359	662-7088	36fore@state.nd.us
49	Traill	Valorie Ladwig	West Caledonia Avenue	PO Box 190	Hillsboro, ND 58045	636-5220	636-5221		49ladv@state.nd.us
50	Walsh	Twila Novak	516 Cooper Ave, 2nd floor		Grafton, ND 58237-1399	352-5111	352-5060	352-4526	50novt@state.nd.us
51	Ward	Daniel Richter	400 22nd Avenue NW	PO Box 2209	Minot, ND 58702-2209	852-3552	857-0756	857-0732	51ricd@state.nd.us
52	Wells	John Mogren	600 North Railway	PO Box 266	Fessenden, ND 58438	547-3694	547-3348	547-3694	52mogj@state.nd.us
53	Williams	Michon Sax	110 W Broadway Ste 202		Williston, ND 58801-6032	774-6300	572-9794		53saxm@state.nd.us

SOCIAL SECURITY ADMINISTRATION

National Toll-Free 1-800-772-1213

Bismarck Area	Social Security Office 1680 East Capitol Avenue Bismarck, ND 58501-5603	250-4200 250-4230 - fax 800-305-6526
Dickinson Area	Social Security Office 265 First Avenue West Dickinson, ND 58601	225-9178 225-9400 - fax 800-305-6526
Devils Lake Area	Social Security Office 221 Second Street West Devils Lake, ND 58301	662-6290 662-2824 - fax
Fargo Area	Social Security Office Federal Building, Room 320 657 North Second Avenue Fargo, ND 58102	239-5607 239-5474 - fax 800-453-7255
Grand Forks Area	Social Security Office 124 North Sixth Street Grand forks, ND 58203	772-5518 772-8622 - fax 877-772-2467
Jamestown Area	Social Security Office 1604 Sixth Avenue SW Jamestown, ND 58401	252-6024 251-1511 - fax
Minot Area	Social Security Office Federal Building, Room 104 100 First Street SW	852-0604 839-4602 - fax 866-541-3299
Williston Area	Social Security Office 1137 Second Ave W, Suite 102 Williston, ND 58801	572-0682 572-3024 - fax

NORTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS
MAIN OFFICE--1 2nd Street S, P. O. Box 9003, Fargo, ND 58106-9003
TEL: 701-239-7165 FAX: 701-239-7166
TOLL-FREE: 1-866-634-8387

April 22, 2004

BRANCH OFFICE
1929 N. Washington, PO Box 7184
Bismarck ND 58507-7184
TEL: 701-328-5465 FAX: 701-328-5468

#	COUNTY	SERVICE OFFICER		MAILING ADDRESS		HOURS	TELEPHONE WORK	TELEPHONE HOME	FAX	FY02 VET POP
01	ADAMS	Arnold K. Scott	none	Box 686	Hettinger 58639	No Regular Hours		567-4283	567-2910	243
02	BARNES	James T. Drong jdrong@co.barnes.nd.us	none	230 4th St NW, Room 103	Valley City 58072	M-F, 8-5	845-8511	646-6561	845-8590	1,162
03	BENSON	Jo Dahlen ~~Wayne Stautz~~ ~~wstautz@state.nd.us~~	none	Box 52	Minnewaukan 58351	W & Fri 8-4:30	473-5451 ~~662-3567~~ ~~[illegible] ext. 3~~	473-5339	473-5571	486
04	BILLINGS	Roy A. Basaraba	none	2123 Highway 85 SW	Belfield 58622	M-F, 8-5		575-4948		123
05	BOTTINEAU	Dwight Nahinurk nahinurk@ndak.net	none	411 Main Street Memorial Building	Bottineau 58318	M & W 9-3	228-3904	263-4700	228-2336	711
06	BOWMAN	Patricia Ann Sadowsky sadowsky@pop.ctctel.com	none	Box 3	Bowman 58623	No regular hours		523-5512	523-5443	238
07	BURKE	Allen Ryberg bowins@nccray.com	none	Box 10	Bowbells 58721	M-F, 9-4 On call remaining days	377-2739	377-2813	377-2799	248
08	BURLEIGH	Mark Landis mlandis@state.nd.us	Cindy Munsch cmunsch@state.nd.us Joyce Hochhalter jhochhal@state.nd.us	Box 5518 221 N 5th St	Bismarck 58506-5518	M-F, 8-5	222-6698	663-2747	222-6420	6,585
09	CASS	James Brent Brent@co.cass.nd.us	Chanelle B. Lende (241-5745) Mike Vandrovec (241-5741) vandrovecm@co.cass.nd.us Lendec@cass.nd.us	P. O. Box 2806 1010 2nd Ave S	Fargo 58108	M-F, 8-5--Government Annex	241-5746	298-9369	239-6751	10,287
10	CAVALIER	Anna Spivey aspivey@state.nd.us	none	901 3rd St	Langdon 58249	Tues & Wed--9-12, by appt.	256-2146	256-2867	256-2566	449
11	DICKEY	Steve C. Frojen	none	Box 388 309 2nd Avenue	Oakes 58474-0388 Ellendale	Oakes--1-5:00 M-T,TH-F Ellendale--Wed 1:00-5	742-2223 349-3249 Ext. *830	742-2502		491
12	DIVIDE	Roman Fettig	none	Box 143	Crosby 58730	Flexible	694-2711	965-6948	965-6943	262
13	DUNN	Irene Nelson inelson@state.nd.us	Sarah Galster	Box 130	Dickinson 58602-0130	M-F, 8-5--Courthouse	456-7654	227-1244	456-7628	328
14	EDDY	Alfred Ritzke, Jr.	none	208 3rd Ave S	New Rockford 58356	No regular hours		947-2384		259
15	EMMONS	Alex Ohlhauser	none	500 Schley Ave W	Linton 58552	M & T, 8-4:30 W, 8-12	254-5410	254-4814	254-4012	376
16	FOSTER	Wally Purcell wpurcell@state.nd.us	none	Courthouse, PO Box 80	Carrington 58421	Wed, 9-11:30 Thu, 12:30-4:30pm	652-2170	652-1340	652-2173	295
17	GOLDEN VALLEY		none							192

4/2005

COUNTY		SERVICE OFFICER		MAILING ADDRESS		HOURS	TELEPHONE WORK	HOME	FAX
18	GRAND FORKS	Thomas M. Saddler *Tom.Saddler@gfcounty.com*	Cathy Westensee *Cathy.Westensee@gfcounty.com* Peggy Koehler	Box 5547	Grand Forks 58206	M-F, 8-5 County Office Bldg.	780-8296	795-7062	787-8603
19	GRANT	Jack Heyne *jheyne@state.nd.us*	none	Courthouse, Box 48	Carson 58529	T, W &Th, 1-4	622-3693	622-3098	
20	GRIGGS	Robert Messner	none	Box 32 Courthouse	Binford 58416	Every 2nd & 4th Thursday, 9-12 on call other days	797-3717	676-2720	
21	HETTINGER	Lowell G. Prince	Marlys Prince	Box 211	Regent 58650	No regular hours	563-4542		563-4519
22	KIDDER	A. G. Skip Thomas *agthomas@state.nd.us*	none	Box 225	Steele 58482	Mon 9-5	475-2632 ext. 7	475-2132	
23	LaMOURE	Michial Johnson *mijohnso@state.nd.us*	none	202 4th Ave NE, Box 128	LaMoure 58458	M-F, 9-5	883-5301	883-4274	883-4220
24	LOGAN	James J. Hilzendeger *jhilzend@state.nd.us*	none	301 Bdwy, PO Box 38	Napoleon 58561	M-F, 8:30-4:30 -- Courthouse	754-2239	754-2911	754-2270
25	McHENRY	Francis R. Hoynes *redhoyn@srt.com*	none	Box 93	Towner 58788	Wed 9-11; 1-3 On call other days	537-5724	537-5782	
26	McINTOSH	L. Pete Keaveny	none	23 N 6th Street P. O. Box 707	Wishek 58495-9702	M-Sat 8:30-5:30	452-4228 cell phone: 321-1267	452-4336	
27	McKENZIE	Jerry Samuelson *jsamuelson@4eyes.net*	none	Box 1036	Watford City 58854	M-F, 8-5	444-6853		444-4113
28	McLEAN	Todd Schreiner *tschreiner@state.nd.us*	none	Box 1108	Washburn 58577-1108	M-F, 8-4:30	462-8541 ext. 235		462-3542
29	MERCER	Gerald Beck	none	PO Box 39 Courthouse	Stanton 58571	M & T, 7-3	745-3392	948-2494	745-3579
30	MORTON	Ronald Otto *rotto@state.nd.us*	Lucille Rova	210 2nd Ave NW	Mandan 58554	M-F, 8-5 Courthouse	667-3365	663-7921	667-3284
31	MOUNTRAIL	Gene H. "Skip" Wing *ghw@midstatetel.com*	Lisa Lapica	120 S Main St PO Box 421	Stanley 58784	M-F, 8:30-5:00	628-2063	628-2137	628-3063
32	NELSON	Trish Hodny *phodny@state.nd.us*	none	210 B Avenue W, Ste 202	Lakota 58344	1st,3rd, & 4th Wed—Courthouse, 9-4:30 2nd Wednesday, 9-noon -Courthouse 1-4:30 –McVille Firehouse Community Room	247-2531	247-3301	247-2412
33	OLIVER	Ronald Otto	none	PO Box 188	Center 58530	2nd Tuesday, 8:30-4 Courthouse	794-3404		
34	PEMBINA	Ronald Berg *ronberg@state.nd.us*	none	308 Courthouse Dr #11	Cavalier 58220-4100	Tues, Wed 9-5, Thurs 9-1 M & F--on call	265-4460 cell phone: 520-2704	257-6617	265-4228
35	PIERCE	Dwight Liming	Bertha Liming	309 3rd Street SW	Rugby 58368	Mon -- Courthouse, 8-5	776-6178 776-5680	776-6803	776-5707
36	RAMSEY	Earl H. Hanson *hanson@gondtc.com*	none	524 4th Avenue #17	Devils Lake 58301	Monday 8-5 & Tuesday 8-1 Answering Machine other days Wed [illegible]	662-7048	662-3504	-7092

COUNTY	SERVICE OFFICER		MAILING ADDRESS		HOURS	TELEPHONE WORK	HOME	FAX
37 RANSOM	Richard Wimer *rwimer@pioneer.state.nd.us*	none	P. O. Box 830	Lisbon 58054	M,T, Th, F 8:30-5:00 (Ext. 126) Wed--Vets Home 10:00-5:00	683-5823 683-6500	678-2293	683-5827
38 RENVILLE	William Allen *dandba@srt.com*	none	Box 481	Mohall 58761	M-F, 1-5		756-6403	756-6391
39 RICHLAND	William B. Peschel *bpeschel@pioneer.state.nd.us*	none	418 2nd Avenue N.	Wahpeton 58075	M-F, 8-5 Courthouse	642-7807 cell phone: 701-640-1398	642-2714	642-7808
40 ROLETTE	Beryl Rogers	Joyce Rogers	Box 939	Rolla 58367	Wed, 11-3	477-5265	477-3677	477-6339
41 SARGENT	Norman E. Preble *npreble@state.nd.us*	none	P.O. Box 177	Forman 58032	M-F, 9-12 & 12:30--4:30	724-6241 Ext. 8	724-6335	724-6244
42 SHERIDAN	Paul E. Stober	none	1651 7th St N.E.	Goodrich 58444	No regular hours		884-2658	
43 SIOUX	Giles Heinen	none	Box L	Fort Yates 58538	Monday, 9-1	854-3424	422-3493	854-3854
44 SLOPE	Alvin B. Rotering	none	13607 61ST St. SW	Amidon 58620-9650	Anytime		879-6292	
45 STARK	Irene Nelson *inelson@state.nd.us*	Sarah Galster	Box 130	Dickinson 58602-0130	M-F, 8-5--Courthouse	456-7654	227-1244	456-7634
46 STEELE	Dennis Kubischta *summersharvest@ invisimax.com*	Mary Kubischta	R.R. 1, Box 35	Hope 58046	Anytime		945-2623	945-2597
47 STUTSMAN	Warren Tobin *wtobin@state.nd.us*	Rita Morris	205 6th St SE, LEC	Jamestown 58401	M-F, 8-5	252-9043		252-7087
48 TOWNER	John R. "Jack" Freund	none	Box 279	Cando 58324	Tue, Wed & Thurs 9-5	968-4363	968-3840	968-4367
49 TRAILL	Melbourne L. Johnson	none	Box 785	Hillsboro 58045 Mayville	T&W 8-4:30, Th 1-4:30 Crths Thursday 8:30 - 11:30	636-4414 788-2166	636-4911	636-5418
50 WALSH	Brendan J. Brazil *walshvso@state.nd.us*	none	638 Cooper Avenue	Grafton 58237	M 8-4:30 T, W & TH 8-Noon	352-5030	248-3931	352-5072
51 WARD	Dale E. Braun *wardvets@yahoo.com*	Cindy Almer-Krueger *cindypfeifer@hotmail.com*	P. O. Box 5005	Minot 58702-5005	M-F, 8-4:30	857-6490	852-9588	857-6491
52 WELLS	Dean E. Johnson	none	713 Lincoln Avenue	Harvey 58341	M-F, 9-5	324-2888	324-4120	
53 WILLIAMS	Robert Evans *bobe@co.williams.nd.us*	Helen Askim Deputy VSO *helena@co.williams.nd.us*	Box 2047	Williston 58802-2047	M-F, 8-5:00 Courthouse	577-4550	572-9187	577-4549
TRIBAL SERVICE OFFICERS								
FORT BERTHOLD Three Affiliated Tribes	Thomas Crowsheart Sr. *tcrowsheart@mhanation.com*	Jim Bear, Asst. *jbear@mhanation.com*	404 Frontage Road	New Town 58763-9404	M-F, 8-4:30	627-4781 Ext. 8336	627-4395	627-3805
FORT TOTTEN serving the Spirit Lake Reservation								
STANDING ROCK serving the Standing Rock Sioux	Claudette Walking Elk-Marshall		Box D	Fort Yates 58538	M-F, 8-4:30	854-2077		854-8596

NORTH DAKOTA SHIC Senior Health Insurance Counseling
a program of the North Dakota Insurance Department

NORTH DAKOTA
SENIOR HEALTH INSURANCE COUNSELING PROGRAM
A Program of the North Dakota Insurance Department

The North Dakota Senior Health Insurance Counseling (SHIC) program offers local, volunteer, peer counselors trained in senior health insurance topics including Medicare, Medicare supplement insurance, and long-term care insurance.

Counselors are available through local sponsoring organizations to meet one on one with seniors or family members and other caregivers and assist with questions about Medicare coverage, claims, or paperwork; Medicare supplement insurance or long-term care insurance policy comparisons, paperwork, claims, or appeals. When necessary, volunteers can provide referrals to other agencies or programs.

If you have Medicare, Medicare supplement, or long-term care insurance questions and want to meet with a trained volunteer, contact the person listed at the sponsor nearest you.

SERVICE IS FREE AND CONFIDENTIAL

Location	Program Sponsor	Contact Person	Telephone Number
Ashley	Ashley Medical Center	Lois Schlabsz	288-3433
Bismarck	St. Alexius Eldercare	Karen Shilman Rodger Wetzel	530-7389
	Medcenter One Geriatric Services/Golden Link Program	Jane Morrow	323-6011
Bottineau	St. Andrew's Health Center	Mary Hintz	228-2935
Bowman	Southwest Healthcare Services	Peggy Klewin	523-3214
Cando	Resthaven/Towner County Healthcare Center	Melodee Buresh	968-2554
Carrington	South Central Adult Services	Mavis Larsen	652-3257
Cooperstown	South Central Adult Services	Cindy Flatt	797-3330
Devils Lake	Senior Meals and Services	Jean Aardahl	662-5061
Dickinson	St. Joseph's Hospital	Sue Emmil	456-4646
Fargo	Fargo Senior Commission	Bernie Johnson	293-1440
	The Village Family Service Center	LaDonna Wiederholt	451-4989
Grand Forks	Greater Grand Forks Senior Citizens Association	Joyce Austin	772-7245
	Red River Valley Community Action	Karen Schelinder	746-5431
Harvey	Sheridan Wells County Aging Council	Garnett Lukenbach	324-4032
Hazen	Sakakawea Medical Center	Call SHIC	1-888-575-6611

Location	Program Sponsor	Contact Person	Telephone Number
Hettinger	Hillcrest Care Center	Jolyne Stippich	567-2401
	West River Health Services	Kim Schalesky	567-4561
Jamestown	James River Senior Citizens Center	Cindy Nickerson	252-2882
Killdeer	Hilltop Home	Pam Hartman	764-5682
Langdon	Cavalier County Senior Meals & Services	Beatrice Delvo	256-2828
Lidgerwood	Dakota Estates Retirement Center	Gina Heley	538-4566
Linton	Linton Hospital	Jodi Hulm	254-4511
Marion	South Central Adult Services	Addie Haro	669-2538
Minot	Minot Commission on Aging	Charlotte Zahn	852-0561
	Minot Housing Authority	Brenda Boehler	852-0485
	The Village Family Service Center	Deb Nelson	852-3328
Napoleon	South Central Adult Services	Carrie Becker	754-2791
New Salem	Elm Crest Manor	Jo Hoger	843-7526
Rolla	Presentation Medical Center	Brenda Bergsrud	477-3161
Steele	Kidder County Senior Services	Neda Irish	475-2708
Valley City	South Central Adult Services	Dolly Hoelmer	845-4300
Wahpeton	Southeast Senior Services	Pam Foertsch	642-3033
Watford City	Region I Senior Services	Judy Jacobson	842-3760
Williston	Mercy Medical Center	Carol Miller	774-7445
	Region I Senior Services	Coreen Nehring Karen Froysland	577-6752
	Northwest Human Service Center	Robyn Soiseth	774-4613
Wishek	South Central Adult Services	Carrie Becker	452-2472
	Community Hospital and Clinics	Janine Ogren	452-3113

Sponsor sites may be added or deleted between printings. Program sponsored by the North Dakota Insurance Department with Centers for Medicare & Medicaid Services grant funds. If there is not a program near you, call the North Dakota Insurance Department consumer hotline at 1-800-247-0560 or email at ndshic@state.nd.us. The internet address for SHIC is http://www.state.nd.us/ndins/consinfo/counsel.html.

4/7/05

Fact Sheet
Social Security

2005 SOCIAL SECURITY CHANGES

Cost-of-Living Adjustment (COLA):

Based on the increase in the Consumer Price Index (CPI-W) from the third quarter of 2003 through the third quarter of 2004, Social Security and Supplemental Security Income (SSI) beneficiaries will receive a 2.7 percent COLA for 2005. Other important 2005 Social Security information is as follows:

Tax Rate	2004	2005
Employee	7.65%	7.65%
Self-Employed	15.30%	15.30%

NOTE: The 7.65% tax rate is the combined rate for Social Security and Medicare. The Social Security portion (OASDI) is 6.20% on earnings up to the applicable taxable maximum amount (see below). The Medicare portion (HI) is 1.45% on all earnings.

Maximum Earnings Taxable:	2004	2005
Social Security (OASDI only)	$87,900	$90,000
Medicare (HI only)	No Limit	

Quarter of Coverage:	2004	2005
Earnings required	$ 900	$ 920

Retirement Earnings Test Exempt Amounts:	2004	2005
Under full retirement age NOTE: One dollar in benefits will be withheld for every $2 in earnings above the limit.	$11,640/yr. ($970/mo.)	$12,000/yr. ($1,000/mo.)
The year an individual reaches full retirement age NOTE: Applies only to earnings for months prior to attaining full retirement age. One dollar in benefits will be withheld for every $3 in earnings above the limit.	$31,080/yr. ($2,590/mo.)	$31,800/yr. ($2,650/mo.)

There is no limit on earnings beginning the month an individual attains full retirement age (65 and 4 months for retirees born in 1939; 65 and 6 months for those born in 1940).

Social Security Disability Thresholds:		2004	2005
Substantial Gainful Activity (SGA)	Non-Blind	$ 810/mo.	$ 830/mo.
	Blind	$1,350/mo.	$1,380/mo.
Trial Work Period (TWP)		$ 580/mo.	$ 590/mo.

Maximum Social Security Benefit: Worker Retiring at Full Retirement Age in	2004	2005
NOTE: For retirees born in 1939, full retirement age is 65 and 4 months; for those born in 1940, it is 65 and 6 months. Full retirement age will gradually increase to age 67 for those born in 1960 and later.	$1,825/mo. (Age 65 and 4 months)	$1,939/mo. (Age 65 and 6 months)

SSI Federal Payment Standard:	2004	2005
Individual	$ 564/mo.	$ 579/mo.
Couple	$ 846/mo.	$ 869/mo.

SSI Resources Limits:	2004	2005
Individual	$2,000	$2,000
Couple	$3,000	$3,000

SSI Student Exclusion Limits:	2004	2005
Monthly Limit	$1,370	$1,410
Annual Limit	$5,520	$5,670

Estimated Average Monthly Social Security Benefits Payable in January 2005:	Before 2.7% COLA	After 2.7% COLA
All Retired Workers	$ 930	$ 955
Aged Couple, Both Receiving Benefits	$1,532	$1,574
Widowed Mother and Two Children	$1,927	$1,979
Aged Widow(er) Alone	$ 896	$ 920
Disabled Worker, Spouse and One or More Children	$1,458	$1,497
All Disabled Workers	$ 871	$ 895

SSA Press Office 440 Altmeyer Bldg. 6401 Security Blvd.
Baltimore, MD 21235
410-965-8904 FAX 410-966-9973

Best's Rating

Best's Ratings are assigned and updated throughout the year to insurers which meet our standards for the quantitative and qualitative analysis of the company's financial condition and operating performance. **Rating Modifiers** are added to Best's Ratings to identify companies whose assigned ratings are based on an affiliation with other insurers (g,p,r); or to identify ratings that are under review and may be subject to change (u). The **Effective Date** indicates the rating's publication date. For a more detailed explanation of Best's Rating System see the Preface, Section III or the *Guide to Best's Ratings.*

Current Best's Ratings and Effective Dates reflect the most recent rating assignment given to a company. **Prior** Best's Ratings and Effective Dates reflect the rating assignment given to a company in the recent past. Where appropriate, this will be updated to reflect quarterly data.

Data for these fields can be searched and sorted by accessing the Ratings tab in the Search or Sort dialog. The Current Best's Rating and Current Best's Rating Modifier can also be searched or sorted by accessing the Key Financial Data tab.

	Secure Ratings	(Introduced in 1994)
A++	(Superior)	
A+	(Superior)	
A	(Excellent)	
A-	(Excellent)	
B++	(Very Good)	
B+	(Very Good)	
	Vulnerable Ratings	(Introduced in 1994)
B	(Fair)	Termed "Adequate" prior to 1997
B-	(Fair)	Termed "Adequate" prior to 1997
C++	(Marginal)	Termed "Fair" prior to 1997
C+	(Marginal)	Termed "Fair" prior to 1997
C	(Weak)	Termed "Marginal" prior to 1997
C-	(Weak)	Termed "Marginal" prior to 1997
D	(Poor)	Termed "Very Vulnerable" prior to 1997
E	(Under Regulatory Supervision)	Termed "Under State Supervision" prior to 1997
F	(In Liquidation)	Termed "Liquidated" prior to 1997
S	Rating Suspended	Introduced in 1996
NR-1	Insufficient Data	Introduced in 1996, Termed "Limited Data Filing" prior to 199
NR-2	Insufficient Size and/or Operating Experience	Introduced in 1996
NR-3	Rating Procedure Inapplicable	Introduced in 1996
NR-4	Company Request	Introduced in 1996
NR-5	Not Formally Followed	Formerly N/F (Not Followed)
NA-1	(Special Data Filing)	Discontinued in 1996
NA-2	(Less than Minimum Size)	Discontinued in 1996
NA-3	(Insufficient Operating Experience)	Discontinued in 1996
NA-4	(Rating Procedure Inapplicable)	Discontinued in 1996
NA-5	(Significant Change)	Discontinued in 1996
NA-6	(Reinsured by Unrated Reinsurer)	Discontinued in 1996
NA-7	(Below Minimum Standards)	Discontinued in 1993
NA-8	(Incomplete Financial Information)	Discontinued in 1996
NA-9	(Company Request)	Discontinued in 1996
NA-10	(Under State Supervision)	Discontinued in 1993
NA-11	(Rating Suspended)	Discontinued in 1996

Modifiers

r	(Reinsured Rating)
p	(Pooled Rating)
g	(Group Rating)
u	(Rating Under Review)

Financial Size Category

The **Financial Size Category** is an indicator of the size of an insurer, and is based on reported Policyholders' Surplus plus conditional or technical reserve funds, such as the asset valuation reserve, other investment and operating contingency funds and/or miscellaneous voluntary reserves reported as liabilities.

The Current field is searchable and sortable by accessing the Ratings tab of the Search or Sort dialog. The Current FSC can also be searched or sorted on through the Key Financial Data tab in the Search or Sort dialog.

See Preface, Section IX for complete details. Where appropriate, this field will be updated to reflect quarterly data.

The **Financial Size Code** is a two digit numeric representation of the category.

Category	Code	Millions of dollars		
I	1	Up	to	1
II	2	1	to	2
III	3	2	to	5
IV	4	5	to	10
V	5	10	to	25
VI	6	25	to	50
VII	7	50	to	100
VIII	8	100	to	250
IX	9	250	to	500
X	10	500	to	750
XI	11	750	to	1,000
XII	12	1,000	to	1,250
XIII	13	1,250	to	1,500
XIV	14	1,500	to	2,000
XV	15	2,000	or	greater

Prescription Drug Discount Plans

Most prescription drug discount plans are not approved insurance plans regulated by the North Dakota Insurance Department. Many come on the market quickly and leave quickly.

Since plans are set up in different ways, here are some questions to ask before you buy.

Eligibility

- Do you have to be a member of an association to enroll?
- Does the plan cover you alone, your spouse, or your family?
- Is there an age requirement to join?

Benefits

- Will prescription for pre-existing conditions be covered? Is there a limit on benefits for pre-existing conditions?
- Are drugs provided through a mail order service, walk in pharmacy, or both?
- Will the plan cover generic drugs, brand name drugs, or both?
- Are my current prescriptions covered?
- What drugs are not covered?
- Must I use a "participating pharmacy"? If so, can I get a list of these pharmacies?
- Can I get price quotes for my prescriptions before I buy?
- Is a minimum order amount required?
- Do I have to pay shipping and handling charges?

Costs

- Is there a membership or enrollment fee?
- Is there a monthly premium or maintenance fee?
- Can I be dropped from the plan for reasons other than not paying the premium?
- What are my copayments?
- Are there any payment options?
- Is there an annual maximum on the benefits I can receive?
- Will the money I save be greater than all of the costs of the plan?

Consumer Protection

- Is this an insurance policy approved for sale in North Dakota?
- Is there a customer service toll-free line?
- Have any complaints been filed against the plan?

Seniors who have questions about prescription drug discount plans can call SHIC at 1-800-247-0560. Because the North Dakota Insurance Department does not regulate this type of product, we will not have

specific information about the plans. We can suggest questions seniors should be asking before enrolling in a prescription drug discount plan.

AARP (American Association of Retired Persons) Pharmacy Service

AARP has a mail order pharmaceutical program for persons of all ages. There is no membership fee and you **do not** have to belong to AARP to utilize this service. This program supplies both generic and brand name medications.

When you get a prescription from your doctor, you can call the AARP Pharmacy Service to get three price quotes: one for brand name, one for generic, and one for quantity purchases. Be sure to check with your local pharmacy to compare prices before you purchase. The AARP Pharmacy Service toll-free number is 1-800-456-2277. Seniors using this service should allow **10 days** to receive the medications.

Veterans/Retired Service Personnel

Veterans and retired service personnel have options for prescription drug service. The Burleigh County Veterans' Service Officer will explain the options.

Prescription Drug Patient Assistance Programs

Many pharmaceutical manufacturers have special programs to assist people who can not afford to buy the drugs they need. Each company has its own program with special requirements, forms, and procedures. Some companies may have different procedures for different drugs.

All companies require the doctor's involvement. The patient should ask the doctor about the programs. Patients are eligible for a limited time. They need to reapply with no guarantee of acceptance.

The Prescription Drug Patient Assistance programs **are not immediate needs programs. It can take from 4-6 weeks to receive medications. Seniors should ask their physicians for samples of the needed medications.** Also, they should ask if there are generic or other lower cost alternatives to their drugs or if drugs could be purchased in larger dosages then cut to the proper dose amount.

Patients can act as their own advocate, ask a family member to be an

advocate for them, or in some counties outreach workers will assist seniors.

Some companies publicize their programs; others do not. There is no central clearinghouse for this information so it is hard for seniors to learn about the drug assistance programs.

Several resources for the pharmaceutical prescription drug programs are www.needymeds.com. A sample sheet for the requirements to obtain several drugs is included. They also publish a manual for those who do not have computer access.

The Robert Wood Johnson Foundation sponsors a website, www.rxassist.org, that includes a search engine to locate assistance programs by searching on company name, brand name, and generic name or by drug class.

The Pharmaceutical Research and Manufacturers of America (PhRMA) publishes a directory of Prescription Drug Patient Assistance Programs (www.phrma.org/).

Other resources for those needing immunosuppressive drugs:

- Call the National Kidney Foundation 800-622-9010.
- Call the American Kidney Fund 800-638-8299.
- Talk with a social worker at the transplant center where the surgery was performed.
- Call the company that produces the drugs (use resources listed above).
- Call a legislative representative.

Legal Services

Legal Services of North Dakota (LSND), a nonprofit organization, provides legal services to disadvantaged elderly and low-income North Dakotans who cannot afford an attorney.

LSND accepts cases in the areas of government benefits, family, health, consumer, housing, elderly law, and Indian law. Specific types of cases that are given highest priority by LSND are:

1. TANF/Teem/AFDC
2. Food stamps

3. General Assistance (GA)
4. LIHEAP
5. Unemployment compensation
6. Medicaid
7. Contested domestic violence protection orders on behalf of the victim
8. Public housing problems
9. Tenant evictions
10. Problems with bills/debts
11. Selected children's issues
12. Child custody defense enforcement
13. Access to justice issues
14. Earned income tax credit
15. SSI

Additional legal help is available for the elderly in:

1. Nursing home transfer and discharge
2. Social Security and Medicare
3. Home health care
4. Durable power of attorney health care
5. Challenging/revoking guardianships
6. Mortgage retention advice

Additional legal help is available through the Indian Law Unit, Turtle Mountain Reservation in the areas of:

- Children's rights/student's rights
- Selected custody and child welfare
- Government benefits
- Housing

Legal Services of North Dakota has offices in several cities within the state but maintains a single intake statewide telephone number for all LSND offices. A person asking for assistance at a local office will be asked to first call the universal toll-free number, 1-800-634-5263, or in Minot, 852-3870. The mailing address for the Minot office is:

LSND
P.O. Box 177
Minot, ND 58702

The Indian Law Unit gives priority to elderly and those who have a mental disability in priority cases. You may contact LSND by calling the toll-free

number at 1-800-634-5263, Monday, Wednesday, or Friday from 8:30 a.m. to 12:00 noon or 1:00 p.m. to 4:30 p.m. Individuals with emergencies or those over 60 can call any week day. All contacts are confidential.

North Dakota Health Care Review, Inc. (NDHCRI) (QIO)

The NDHCRI is the peer review-quality improvement organization for North Dakota. NDHCRI is the Medicare beneficiary's advocate, ensuring that their rights to quality health care are protected.

1. NDHCRI is a private, non-profit group of licensed, actively practicing ND physicians who help Medicare oversee the care provided to beneficiaries in the state.

2. Medicare contracts with NDHCRI to review beneficiary's questions regarding the utilization and quality of care received at:

   a. Hospitals

   b. Skilled nursing facilities

   c. Home health agencies

   d. Emergency rooms

   e. Ambulatory surgical centers

   f. Observation beds or hospital outpatient department

3. NDHCRI deals only with Medicare beneficiaries who have received treatment in a Medicare- certified facility for a service normally covered by Medicare. Review is not coverage related.

4. To process a complaint, call or write NDHCRI with the following information:

   a. Name

   b. Medicare number

   c. Provider involved

d. Nature of the complaint

e. Dates the care was delivered

5. Complaints are investigated and the beneficiary will receive information in writing regarding the outcome of the review.

6. To contest early dismissal from a hospital follow a specific procedure which is outlined on the handout "An Important Message from Medicare" each patient receives upon admittance (pages D-15 and N-22).

This form (pages N–23 and N–24) has been superceded by
Form No. CMS-R-193 (January 2002). See page D-15.

AN IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

✓ You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, **your discharge date must be determined solely by your medical needs,** not by "Diagnosis Related Groups" (DRGs) or Medicare payments.

✓ You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for any post-hospital services.

✓ You have the right to request a review by a Peer Review Organization (PRO) of any written Notice of Noncoverage that you receive from the hospital stating that Medicare will no longer pay for your hospital care. PROs are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness, and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area is:

North Dakota Health Care Review, Inc.
800 31st Ave. S.W.
Minot, ND 58701
(800) 472-2902

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. **If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor.** The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

✓ Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage." You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

✓ The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.

If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation, the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage, but since the PRO has already reviewed your case once, you may have to pay for **at least one day of hospital care** before the PRO completes its reconsideration.

IF YOU **DO NOT** REQUEST A REVIEW, **THE HOSPITAL MAY BILL YOU** FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

✓ If the Notice of Noncoverage states that your **physician agrees** with the hospital's decision:

- You must make your request for review to the PRO by **noon of the first work day** after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.
- The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone and in writing of its decision on the review.
- If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day **after** you receive the PRO's decision.
- Thus, you will **not** be responsible for the cost of hospital care before you receive the PRO's decision.

✓ If the Notice of Noncoverage states that the **PRO agrees** with the hospital's decision:

- You should make your request for reconsideration to the PRO **immediately** upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.
- The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
- Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage **even if the PRO has not completed** its review.
- Thus, if the PRO continues to agree with the Notice of Noncoverage, **you may have to pay for at least one day of hospital care.**

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative, and your family in making preparations for care after you leave the hospital. **Don't hesitate to ask questions.**

ACKNOWLEDGMENT OF RECEIPT – My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

_____	_____
Signature of Beneficiary or Person Acting on Behalf of Beneficiary	Date of Receipt

TRICARE (DoD Health Plan)

TRICARE is the managed care component of the Civilian Health and Medical Program of Uniformed Services (CHAMPUS) program. CHAMPUS/TRICARE provides medically necessary treatment, drugs, equipment, and supplies for the following services: Army, Navy, Marine, Air Force, Coast Guard, PHS, and National Oceanic and Atmospheric Administration (NOAA).

Eligible beneficiaries:

1. Active duty family members
2. Retired military members and families
3. Certain former spouses
4. Unremarried widows/widowers

On October 30, 2000, President Clinton signed the National Defense Authorization Act. Two major things came out of the bill:

- **Beginning April 1, 2001, TRICARE beneficiaries 65 and over are entitled to the same pharmacy benefit as retirees under 65**. It includes access to prescription drugs not only at military treatment facilities, but also at retail pharmacies and through TRICARE's national mail order pharmacy. For beneficiaries who turn 65 prior to April 1, 2001, beneficiaries automatically qualify for the pharmacy benefit under the law, whether or not they have purchased Medicare Part B. For beneficiaries who attain the age of 65 on or after April 1, 2001, the law mandates that they must be enrolled in Medicare Part B to receive the TRICARE pharmacy benefit.

- **Beginning October 1, 2001, Medicare-eligible military beneficiaries become eligible for all other TRICARE benefits.** The law requires that all Medicare-eligible beneficiaries regardless of age or when they turn 65 must be enrolled in Part B to receive the rest of the TRICARE benefit. TRICARE becomes the second payer to Medicare for medical care that is a benefit under both Medicare and TRICARE. Medicare will pay the allowable amount for the care, and TRICARE will pay the amount that is the Medicare cost share, as well as the Medicare deductible.

Indian Health Service/ Contract Health Services

Indian Health Service has 12 areas through the United States and is under the Department of Health and Human Services. Funding is provided by the U.S. Department of Interior.

Aberdeen Area covers North Dakota, South Dakota, Nebraska, and Iowa.

Area Office is located in Aberdeen, South Dakota, telephone: (605) 226-7575.

Aberdeen Area Indian Health Directory of North Dakota

Belcourt Indian Health Hospital
P.O. Box 160
Belcourt, ND 58316
(701) 477-6111 Fax: (701) 477-8410

Fort Berthold IHS Health Center
HC 2, Box 24F
New Town, ND 58763
(701) 627-4701 Fax: (701) 627-4318

Fort Totten IHS Health Center
P.O. Box 200
Fort Totten, ND 58335
(701) 766-1600 Fax: (701) 766-1620

Fort Yates IHS Hospital
P.O. Box J
Fort Yates, ND 58538
(701) 854-3831 Fax: (701) 854-3685

Trenton-Williston Health Center
P.O. Box 210
Trenton, ND 58853
(701) 774-0461 Fax: (701) 774-8003

The following suggestions/information are provided to assist the service units in identifying and obtaining appropriate information for direct and CHS care.

General Eligibility Requirements:

1. Must be an enrolled member OR descendent of enrolled member of Federally Recognized Tribe.
2. Eligibility will be extended to non-Indians in only three (3) situations:
   a. Non-Indian woman pregnant with eligible Indian's child for duration of pregnancy through 6 weeks post-partum for pregnancy related care only.
   b. Non-Indian member of eligible Indian's household -public health hazard only
   c. Non-Indian:adopted,foster,step-child(ren) of eligible Indian until age of 19 yrs.(PL100-713)

*Note:*Non-Indian patients who do not meet the above but present at IHS emergency room for emergency care(prevent immediate death,serious impairment to life,limb,senses)can be treated,stablized and routed to a non-IHS facility with patient responsible for costs.
*Note:*Non-Indians who do not meet the above, present at IHS are to be informed they are not eligible and must obtain their non-emergency care elsewhere.

Suggestions on information needed to open a medical chart at IHS.

(copies to be made for the medical chart)

1. Proof (enrollment paper) of being a member or descendent of member(parent(s) or grandparent(s) enrollment papers, birth certificates etc to show lineage.
2. Proof of pregnancy (can be peformed at IHS) of non-Indian woman with:
   Marriage certificate if married to eligible Indian.
   If non-Indian woman is not married to eligible Indian - notarized paternity affidavit.
3. Public Law 100-713 "Health Services for Ineligible Persons"
   a. Must be under 19 years of age
   b. If not adopted, must be residing with eligible Indian with notarized statement from eligible Indian attesting to the fact that child(ren) are under his/her guardianship and effective date (i.e. court papers) and proof from school child(ren) are enrolled in school with beginning date, who is listed as parents or guardian.
   c. If adopted, adoption papers and birth certificate of child(ren) and eligible Indian's proof of tribal membership or descendency.

Suggestions to determine eligibility and residency for CHS Program:

(copies to be made for CHS files)

1. A rent or utility receipt and/or receipt on PO Box rental.
2. If patient does not reside in own home, a notarized statement from the patient and person they reside with stating date the patient started living at that residence.
3. If patient is under BIA general assistance, a statement from BIA social worker with date GA started wtih current address.
4. If patient is under State Medicaid-a copy of Medicaid card
5. If employed: statement from employer showing proof of employment and dates employed.

This information is provided using the 42 CFR-CHS Program's published regulations, IHS/CHS Manual, IHS Policies. This information can be used as training material, for Service Unit's policy and procedures manual, to educate IHS staff, patients and vendors.

WHAT ARE CONTRACT HEALTH SERVICES (CHS) ?

These are health services which are provided at the expense of Indian Health Service (IHS) from public or private facilities. These services are in addition to those services provided at an IHS facility. **A referral is not an implication that IHS will pay for the care.**

General Eligibility Requirements: To meet the requirements... You must be an Indian (member) from a Federally Recognized Tribe and live on the reservation....OR..you must be a member who lives Near your reservation in the CHS Delivery Area...OR..if you are not a member of the Tribe and you live near the reservation (CHSDA) and the Tribe recognizes you as having "close social and economic ties" with them by a documentation of: marriage to tribal member, employment with the tribe or documentation from the tribe (i.e. Resolution) for other reasons the tribe may deem as close social/economic ties

Other Persons Eligible for Services Include: Will be reviewed on an individual basis.
Indians adopted by non-Indians and Indian children in foster homes.
Eligibility for IHS shall be extended to non-Indians in only three (3) situations:

1) Non-Indian woman pregnant with an eligible Indian's child for duration of pregnancy through post-partum
2) Non-Indian member of an eligible Indian's household-public health hazard situation
3) Adopted, foster and step-children of eligible Indian - until age 19

Persons NOT Eligible are:

1) Non-Indian widows/widowers/divorcees of eligible Indians
2) Non-Indian spouses of eligible Indians (except pregnancy as stated above)
3) Members of terminated tribes
4) Canadian Indians and Mexican Indians

Alternate Resources: IHS is payor of last resort. If other resources are available and accessible, it is mandatory that the patient apply and utilized the resource as long as there is no cost to the patient. If other resources such as health care providers, institutions (includes IHS facilities), Medicare, private health insurance, workmen's comp, automobile insurance etc. are available they must be used before CHS funds are expended.

Limited Services: Must still meet notification requirements, medical priorities of care and use of alternate resources. Services will be limited to transients (temporarily employed off the CHS Delivery Area) and students. For persons who move off the CHS Delivery Area - eligibility will only continue for 180 days.

Notification Requirements: Patient's responsibility but vendors may also notify IHS.

Non-Emergency: Approval for the care must be obtain before the care is provided.

Emergency: IHS must be notified within 72 hours on initiation of treatment. IHS may request medical information and a bill to review.

IHS MUST ISSUE A MPO OR DENIAL FOR EACH PATIENT: A denial may be issued for the following reasons: (1) Eligibility (2) Alternate Resources (3) No prior approval/non-emergency care (4) No notification within 72 hours for emergency care (5) Not within medical priority (6) Services could have been provided at an IHS facility.

BASIC GUIDELINES FOR RELATING TO PERSONS WITH DISABILITIES

Here are some very basic guidelines for relating to people with disabilities, most of which will already come naturally to you:

* **Use common sense.** People with disabilities want to be treated the same way everyone else does.

* **Don't be patronizing.** Show the person the same respect that you expect to receive from others. Treat adults as adults.

* **Be considerate and patient.** Anticipate what the person's needs might be and offer assistance when possible. Be patient if the person requires more time to communicate, to walk, or to accomplish various tasks. When planning a meeting or event, consider their needs ahead of time.

* **Don't put unnecessary pressure on yourself to know and do everything "right".** Be patient with yourself in learning what the specific needs of the person are. Don't be embarrassed if you find yourself doing or saying the wrong thing. Remember that the person with a disability is usually aware of and sensitive to your discomfort and your good intentions in the situation.

* **Don't be afraid to offer assistance.** If it appears that the person is in need of some assistance, offer it by asking if there is something you can do. However, do not automatically give help unless the person clearly needs or has asked for it.

* **Communicate with the person, not his or her interpreter, companion, or assistant.**

* **Respect the person's privacy.** If you find yourself speculating about areas of the person's private life or medical condition (unrelated to the job), refrain from asking questions which would otherwise be inappropriate to ask of any other person.

* **Be aware of the language that you use in relation to people with disabilities.** Refer to the **Guide to Acceptable Terminology in the Field of Disability**.

* **Learn what you can about the proper etiquette and protocol for relation to persons with the specific disabilities.** For recommendations on relating to people with specific disabilities, refer to the **Guide to Etiquette and Behavior for Working with Persons with Disabilities**.

GUIDE TO ETIQUETTE AND BEHAVIOR FOR WORKING WITH PERSONS WITH DISABILITIES

The following summary contains many true statements, but no absolute truths. Every person with a disability is different. While this summary is about disabilities, it is important to remember that you are not working with disabilities, you are working with individuals who have disabilities. So, all of the following guidelines are valid until someone with a disability tells you that they want it done in some other way. With this in mind, the following general guidelines are offered:

DISABILITY - BLIND AND/OR VISUALLY-IMPAIRED

THINGS TO KNOW:

* The definition of legally blind is 20/200 vision with best correction. Many more persons who are considered blind have some sight, rather than no sight at all.

* Many persons who are blind are quite mobile and independent. Some people who are blind view blindness not as a disability as much as an inconvenience.

* While many persons who are blind can use braille, the majority of persons who are blind do not.

THINGS TO DO:

* Introduce yourself. Identify who you are and what your job or role is. Give the person verbal information that is visually obvious to those who can see.

* Be descriptive when giving directions. Saying, "Over there," has little meaning to someone who cannot see your point. "Four doors after turning right from the elevator," would be much more helpful.

* Lead someone who is blind only after they have accepted your offer to do so. Allow them to hold your arm rather than you holding them. It is important to let them control their own movements. Verbally describe the area as you go.

* Describe things from their perspective, not yours. Some persons who are blind use a "clock" reference for things directly in front of them such as a meal. For example, something could be positioned at three o'clock (to their right) or six o'clock (directly in front and close). Before using this strategy, ask the person if this is useful to them.

* Face the person with a visual impairment when talking. If your eyes are directed towards the person, your voice will be as well.

* Tell them when you have brought new items into their environment, describing what they are and, most importantly, where you have put them.

THINGS TO AVOID:

* Do not move items (furniture, personal items) after their position has been learned by the person. This can be frustrating and, in some cases, dangerous for the person.

* Do not use references that are visually-oriented like, "Over there near the green plant."

* Do not interact with a dog guide while it is working (in harness).

THINGS TO CONSIDER:

* Persons who are blind and/or visually impaired are by and large much more independent than people give them credit for. Many times, negotiating the physical environment is less frustrating than trying to communicate with persons who are not sensitive to their needs.

* Persons who are blind have a long history of being patronized and talked to as if they were children. They have more often been told what to do rather than asked what they would prefer doing. This attitude is not acceptable towards any person.

DISABILITY - DEAF AND/OR HEARING-IMPAIRED

THINGS TO KNOW:

* More persons who are deaf or hearing-impaired have some hearing rather than no hearing at all.

* Sign language is not another form of English, it is an official language with its own grammar, contexts and rules.

* Lip-reading, while helpful without sound clues, is only 30%-50% effective, and sometimes less.

* Long conversations with persons who lip-read can be very fatiguing to the person who has the impairment.

* Not all persons who are deaf use sign language.

* Not all persons who are deaf write and read.

* Not all persons who are deaf speak.

* Not all persons who are deaf lip-read.

THINGS TO DO:

* Find out how the person best communicates.

* If the person uses an interpreter, address the person, not the interpreter.

* If the person reads lips, speak in a normal, not exaggerated way. Short, simple sentences are best.

* If the person lip-reads, avoid blocking their view of your face. Make sure the lighting is good.

* Gain their attention by tapping their shoulder or waiving your hand in front of them before starting a conversation.

* If there is some doubt in your mind whether they understood you correctly, rephrase your statement and ask them if you have been understood.

* Be aware of situations where a person may be waiting for a service (transportation, a table, the start of an activity) where the common way to communicate is an announcement or the calling of the person's name. Make sure you take notes when someone cannot hear you, and develop an alternative way of notifying them.

THINGS TO AVOID:

* Do not become impatient or exasperated with the person if it takes longer to communicate.

* Make sure there are no physical barriers between you and the person while in conversation.

* If the person is using hearing aids, avoid conversations in large, open and noisy surroundings.

THINGS TO CONSIDER:

* Persons who may deal very well one-on-one in communication may have a hard time with two or more speakers, especially if there are many interruptions and interjections.

* Showing impatience to someone who is deaf or hearing-impaired may cause the less assertive to back off from telling you of their needs.

* When someone asks, "What did you say?" the answers, "Never mind," "Nothing," or "It's not important," are very common replies. These are insulting and demeaning because they communicate that the person is not worth repeating yourself for.

DISABILITY - CONDITIONS WHICH CAUSE DIFFICULTY WITH SPEECH

THINGS TO KNOW:

* There are many reasons for having difficulty with speech. Deafness, cerebral palsy, stroke, head injury, physical malformation of speech mechanisms, and general speech impairment are just a few.

* It is not unusual in stressful situations for someone's speech to become harder to understand.

THINGS TO DO:

* If you do not understand what the person is saying, bring it to their attention immediately and ask how the two of you may better communicate.

* If it is a stressful situation, try to stay calm. If you are in a public area with many distractions, consider moving to a quiet or private location.

* Consider writing or using a computer as an alternative means of communication.

* If no solution to the communication problem can be worked out with you and the person, consider asking if there is someone who can translate or interpret what they are saying.

THINGS TO AVOID:

* Do not pretend to understand them when you really do not.

* Do not interrupt and wait for sentences to be completed.

* Do not become impatient or exasperated with the communication.

* Do not finish people's sentences for them.

THINGS TO CONSIDER:

* Many persons with difficulty in speech find themselves in situations where people treat them as if they are drunk, retarded or mentally ill. They are accustomed to being avoided, ignored, even hung up on by phone.

* Accessibility for persons with difficulty in speech lies within your power. Your understanding, patience and communication skills are as important to someone with speech that is difficult to understand as a ramp or a grab bar is to someone who uses a wheelchair.

DISABILITY - USES WHEELCHAIR

THINGS TO KNOW:

* There are many reasons (not just being paralyzed) for someone to use a wheelchair.

* There is a wide range of physical abilities among those who use wheelchairs. This means that the persons who use them may require different degrees of assistance.

* Some persons do not use wheelchairs exclusively, but may also use canes, leg braces, and in some cases, no assistive devices at all for short periods.

* Not all wheelchairs are the same. Different sizes and shapes meet different needs. Just because one employee could access an area in his or her chair, does not mean that everyone will be able to do so.

THINGS TO DO:

* If you are asked to fold, carry or store a wheelchair, treat it with the same kind of respect that you would if you were holding someone's eyeglasses. They are similar in many ways. They can break, they are difficult to have repaired on short notice and weekends, and it is extremely disruptive to the user when they are out of commission.

* When speaking to someone who uses a wheelchair, remember to give the person a comfortable viewing angle of yourself. Having to look straight up is not a comfortable viewing angle.

THINGS TO AVOID:

* Do not come up to someone who is using a wheelchair and start pushing them without asking.

* When communicating, do not stand too close to the person in the wheelchair. Give them some space.

THINGS TO CONSIDER:

* It is a very common experience for persons who use wheelchairs to be told that some place is accessible when it is not. Listen carefully when anyone who uses a wheelchair tells you that some area that you thought was accessible is not.

* Do not assume that the person using a wheelchair needs assistance. Ask the person if there is anything special you can provide.

DEVELOPMENTALLY DISABLED

THINGS TO KNOW:

* A developmental disability is a disabling condition that arises in infancy or childhood. This disability can also be caused from a serious head injury.

* This disability can cause problems in language, learning, mobility and capacity for independent living.

THINGS TO DO:

* Speak in concrete terms, use short setences and avoid abstract instructions.

* Complete one step of instructions before instructions for next step are given.

* Demonstrate how things should be done. Pictures are a good form of instruction. Explain what you are doing as you do it.

* Give extra time to complete a task.

* Make sure the person can be successful and praise success.

* Speak in normal voice. If person has an attendant and you have difficulty in communicating with individual with disability, ask attendant for clues to effectively communicate.

THINGS TO AVOID:

* Do not become impatient if the individual does not understand the directions given.

* Do not use terms that describe level of disability.

* Do not attend to behavior that is age inappropriate.

THINGS TO CONSIDER:

* Judgement varies greatly based on level of disability. Expect normal behavior.

* If individual with disability isn't responding, consider the fact that they may have an assistive device. Ask when unsure of best way to communicate.

* Based on level of disability, individual with disability may not be able to ask for personal assistance or follow directions. Look for behavior or body language clues to anticipate individual needs.

GUIDE TO ACCEPTABLE TERMINOLOGY IN THE FIELD OF DISABILITY

ACCEPTABLE	UNACCEPTABLE
Person who is little Person of short stature	Dwarf Midget
Person with down syndrome	Mongol Mongoloid
Person who is deaf Person who is hard of hearing Person who has a hearing impairment	The deaf Stone deaf Deaf and dumb Profoundly deaf
Person with a congenital disability	Birth defect
Person who uses a wheelchair Wheelchair user	Confined to a wheelchair Wheelchair bound
Person with a mental disability Person with an emotional disorder	Lunatic Mentally ill Crazy Mentally disturbed Maniac
Person with a learning disability	Slow Stupid Retarded
Person with a mental disability Person with a developmental disability	Retard Slow learner
Person with cerebral palsy	Spastic
Person with a cleft lip	Hair lip
Person who is blind Person who has a vision impairment	The blind Living in a world of darkness

Person with _____
Person who is _____

Victim of _____
Sufferer of _____
The _____
Afflicted with _____

Person with a speech disorder
Person without speech

Mute
Dumb

Persons with _____
People with _____

The handicapped
The disabled

Non-Disabled

Whole person
Able-bodied person
Health
Normal

Instructions for Completing the Client Contact Form for the State Health Insurance Assistance Program (SHIP)

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0850. The time required to complete this information collection is estimated to average 7-10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

This document provides definitions and instructions for the information that is collected and reported on each contact with a client.

Definition of Client Contacts

Client Contacts: "Client Contacts" includes **all** contacts between counselors or staff and clients which include elders, Medicare or Medicaid beneficiaries, family members or others working on behalf of a client. These contacts can be over the telephone, in person (site), in person (at home), or via postal mail, e-mail, or fax.

Do NOT use the Client Contact Form for:

- persons reached at public events such as presentations or health fairs. Questions asked during or after a presentation are not considered individual client contacts unless one-on-one counseling occurs.

- unsuccessful attempts to reach a client (e.g., leaving messages on an answering machine).

Who Completes the Client Contact Form?

The Client Contact Form is used by registered SHIP counselors only (i.e. individuals who have received counselor training and have signed some type of Counselor Agreement or Memorandum of Understanding). SHIP counselors can include volunteers, staff, toll-free helpline counselors, local coordinators/sponsors, etc.

Client Contact Forms are considered confidential. They must be treated by counselors as confidential information. THE COUNSELOR MUST ASSURE THE CLIENT THAT ALL PERSONAL INFORMATION COLLECTED IS CONFIDENTIAL.

Instructions for Completing the Client Contact Form

All data fields in all sections are REQUIRED fields.

Contact Information (top section of page, before "**Section 1- Beneficiary Information**")

Counselor Name: Enter the name of the registered counselor who provided SHIP services to the client for this contact. If a team of two counselors helped the client, enter the name of the primary counselor (only complete one form). You may enter "NC" (not collected) if you do not have the counselor's name.

Zip Code of Counseling Location: Enter the zip code of the location where counseling occurred. If the contact occurred in more than one location or more than once, enter the location where the first contact occurred. Be sure to enter all five digits of the zip code. Please note this field will not accept zip plus 4.

Type of Client/Assistance Requested by: Check the box or boxes that best describe the type of client or clients who request information or assistance. Check "couple" only if both require SHIP services for the same issue. Check "agency" for professionals calling on behalf of a client or for general information.

Quick telephone calls: Check this box for calls lasting less than 10 minutes. You must still enter a contact date and if possible, topics discussed and any demographic information you have collected.

Date of Initial Client Contact: Enter the date on which the first counseling/assistance session occurred. Do not count contact with a client to merely set up an appointment for a later date.

Date if Multiple Contacts: Enter the date on which an additional contact or counseling/assistance occurred. Counseling sessions occurring on separate days should be entered as a separate contact date, even if the counseling session is a follow-up session on the same topic. You may need to use

additional forms if more than two separate contacts occur on two separate days. You may not enter additional dates unless an initial contact date has been entered. Also, additional dates must be later than the initial contact date.

For clients who require monthly claims/billing assistance (for whom you may have multiple contacts on a regular basis), you may use one form for up to 2 contacts. Make sure to count all time spent during the month on the client's bills.

Type of Contact: This section reports on the five ways in which counselors provide services to help the client resolve his/her insurance-related problem(s). Check whether the contact was made:

- Quick telephone contact (<10 minutes),
- Telephone (> 10 minutes),
- In person (site),
- In person (home visit), or
- Postal mail, e-mail or fax.

Note: If you have a substantial, on-on-one discussion with a beneficiary at another location such as the grocery store or church, you may count this as a contact and check 'in-person (site) as the type of contact.

How did Client Learn About the SHIP? Select one source.

- **CMS (1-800-Medicare, www.medicare.gov, Medicare & You, CMS Mailing)** Check this box if the client learned about the SHIP from a CMS publication, a hotline counselor, CMS website, CMS regional office or other CMS-sponsored source.

- **Presentation/Fair:** Check this box if the client learned about the SHIP at a health fair or presentation sponsored by the SHIP or other organization.

- **State-specific mailings/brochure:** Check this box if the client learned about the SHIP from publicity that your SHIP conducted via mail or SHIP brochures left in community locations or distributed by another agency.

- **Agency:** Check this box if the client was referred by another agency, such as a disability organization, a senior organization, an advocacy organization.

- **Friend/Relative:** Check this box if a friend or relative referred the beneficiary to the SHIP.

- **Media:** Check this box if the client learned about the SHIP from a public service announcement, a newspaper ad, poster, etc.

- **Other:** Check this box ONLY if the response cannot fit into one of the previous categories. Please specify the source.

Time Spent: Time spent represents the total minutes/hours a counselor spent counseling or working directly on behalf of the client for each contact.

This includes the total number of minutes/hours spent on the following activities to resolve the client's issue(s) related to each contact:

- counseling,
- researching,
- referring,
- advocating (calling agencies on the client's behalf),
- trying to reach the client
- waiting to meet with a client,
- traveling,
- preparing materials to send to the client, and
- completing paperwork/forms to report the client contact.

In the blank line(s) provided, write in the *total* number of minutes or hours spent on the case. Note that some of the time spent may take place on a day other than the contact date. For example, you may spend 1 hour with the client on the contact date, 1 hour the next day researching information on behalf of the client and another 20 minutes the following day completing paperwork. Two hours and 20 minutes should be entered as the total time spent next to the initial client contact date. Do not include time spent on non-SHIP activities.

Section 1- Beneficiary Information

Enter the **name**, **zip code**, and **telephone number** of the Medicare beneficiary (or pre-Medicare beneficiary) who is the recipient of SHIP services. This information may be needed to contact the client with follow-up information and to assist with their particular issue or problem. If the beneficiary is deceased, information on the beneficiary's representative should be entered instead.

Note: Please remember to include area code when recording the telephone number.

You may enter "NC" (not collected) if you do not have the beneficiary's name.

For couples needing assistance with the same issue(s), enter the name of the individual who the counselor spent more time speaking with. Exception: if both individuals need assistance with separate issues, please complete a separate form for each individual.

If an agency professional contacts you for information that is not in reference to a specific beneficiary, enter N/A (not applicable) in this field and skip to Section 3. Check "agency" for type of client.

Representative name: If appropriate, enter the name of the person (spouse, relative, friend, agency staff) helping or representing the beneficiary.

Section 2- Beneficiary Demographics

Beneficiary demographic information shall be completed only if a client is contacting SHIP for the first time since April 1. If the beneficiary is deceased, complete this section for the beneficiary's representative you are helping.

Steps:

1. First, ask the client if he/she has received SHIP services since April 1. If not, complete the Beneficiary Demographics Section. Take the word of the client; no check of past records is necessary. If a client is unsure whether they have received SHIP services since April 1, complete this section.

2. Assure the client that the data gathered in this section are confidential and are used for statistical analysis purposes only. Counselors may read the following statement to the client: "The program uses this information to get an idea of which clients we are reaching and which we are not. We can also use this information to demonstrate how many people we reach so that we can continue to get funding to help Medicare beneficiaries. All information we collect is strictly confidential--no names will be attached when reported as totals."

3. Even though you may be uncomfortable asking these questions, demographic information is important data. These data help the SHIP determine whether they are reaching beneficiaries in various demographic groups and if outreach efforts to specific populations is warranted. Also, CMS used this information to gain an understanding of the populations served by the SHIP program.

   The client often communicates demographic information during the course of the counseling session. In these cases, the counselor does not need to ask for it directly.

   Hint: If the contact is in person, the counselor may ask the client to fill in the demographics him/herself. This can be accomplished easily by turning the form around to them and giving them a few minutes to complete it before the counselor continues.

For couples, complete this section for only one individual. (Choose the one you spent more time talking with or who needs most assistance.)

Date of Birth or Age: The counselor may collect either of these items. For the age categories, check the box that applies to the client. For date of birth, simply record this information in the allotted space.

> *Hint*: If the client has not volunteered information about his/her age, it may be easier to ask for date of birth.

Gender: Check the appropriate one.

Monthly income: Check the appropriate box that applies to the client. Check "Not Collected" if the client refuses to reveal his/her income. While income is a sensitive topic, knowledge of a client's income may help the counselor assess whether the client is eligible for Medicaid, QMB, SLMB, or any other needs-based programs. The Federal Poverty Level (or FPL) varies from state to state and is adjusted annually. Your SHIP Program Director will provide you with the FPL income figure for your state. Check the appropriate box to indicate whether the beneficiary's income is above, equal to, or below this figure. Use the $_____ line either to insert the beneficiary's actual income (if you are so told) or, to insert 150% of FPL for your state, to use as reference.

> *Note:* This category refers to the monthly "household" income of the client or the client and spouse only, not relatives with whom the client might be living.

> *Hint*: If the counselor is feeling uncomfortable with this topic, the counselor might tell the client that there are different programs available for different income levels. The counselor can provide a list of the income levels and the programs that correspond with them and ask the client to report which programs sound appropriate to his/her income level. The counselor can then explain these specific programs to the client.

Disabled: Check "disabled" if the client is currently receiving or applying for Medicare/Social Security benefits due to disability or End Stage Renal Disease (ESRD).

Ethnicity/Race: Check the ethnicity/race category that applies to the client.

Hint: It may be helpful to explain to the client that this information is being collected to ensure that SHIP services are accessible to all members of the Medicare community, such that no group is under served.

Section 3- Topics Discussed

Discussed: Many clients need assistance with more than one issue. Section 3 is designed to reflect all major topics discussed during the course of the client contact. For example, if a counselor discusses three topics with a client, then the boxes under the "discussed" heading for all three topics should be checked. Thus, this section provides a count of the specific issues that require counselor assistance to resolve or understand.

Please note: The Centers for Medicare and Medicaid Services (CMS) will apply a formula to the data submitted in order to estimate the amount of money the beneficiary will potentially save as a result of the counseling session. This formula is based on the topics you indicate were discussed. Topics listed in "other (specify)" are not included in this formula. Please make every effort to use the categories listed below to ensure accuracy.

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Prescription Assistance

Medicare Prescription Drug Coverage (PDP/MA-PD)

Plan eligibility, benefit comparisons: includes helping someone understand Medicare Prescription Drug Coverage; what the plans do or do not pay for; and answering eligibility and enrollment questions. Medicare prescription drug coverage is available to all people with Medicare and is provided through a Prescription Drug Plan (PDPs) or a Medicare Advantage Prescription Drug plan (MA-PD).

Low income subsidy - eligibility, benefit comparisons: A person with income below a certain limit (below 150% of the federal poverty level) will get assistance to help pay for their prescription drugs. This includes helping someone understand what Medicare does and does not pay for, or answering eligibility and enrollment questions.

Enrollment/Application assistance: includes providing information to and assisting someone or a personal representative acting on behalf of an individual with enrollment in a Medicare Prescription Drug Coverage plan either on-line with a computer or by assisting with filling out a paper application.

Claims / billing: includes any problems with a Medicare Prescription Drug Coverage plan covering a provider bill or with understanding the claims process that is not resulting in a review, reconsideration, or appeal. Helping a person sort bills and teaching them how to organize billings and claims papers fit into this category.

Appeals/quality of care/grievances: includes contacts associated with a review, reconsideration, or formal appeal regarding an original statement from Medicare.

Other Sources of Prescription Drug Coverage/Assistance

State Pharmacy Assistance Program: includes programs that are administered by states to provide education and prescription drug coverage to qualified individuals. SPAPs provide wrap-around coverage and may provide the same or better coverage as other plans. Costs incurred by SPAPs are counted toward out-of-pocket cost limits when enrolling in a PDP or MA-PD.

Union/Employer plan: Medicare Prescription Drug Coverage is provided through some employers and unions to their retirees. A union or private employer is considered a plan sponsor. They can provide drug coverage in place of Medicare prescription drug coverage; provide drug coverage that supplements the Medicare prescription drug coverage; or pay part or all of Medicare prescription drug plan premiums.

Manufacturers Assistance Program: includes prescription drugs provided by pharmaceutical manufacturing companies at no or low cost to individuals uninsured for prescription drugs..

Discount plans: includes private companies that offer prescription drugs at discounted prices. A discount card can help save on outpatient prescription drug costs. Each drug discount card has a list of pharmacies where the discount card can be used.
Other:

Medicare (Parts A and B)

Enrollment, eligibility, and benefits: includes helping someone understand what Medicare does and does not pay for, or answering eligibility and enrollment questions.

Claims/billing: includes any problems with Medicare covering a provider bill or with understanding the claims process that is not resulting in a review, reconsideration, or appeal. Helping a person sort bills and teaching them how to organize billings and claims papers fit into this category.

Appeals/quality of care/grievances: includes contacts associated with a review, reconsideration, or formal appeal regarding an original statement from Medicare.

Medicare Advantage (PPO, PFFS, specialty plans, managed care)

Enrollment/Disenrollment, eligibility, comparisons etc.: includes helping someone understand how Medicare Advantage plans work, answering eligibility and enrollment questions, reviewing similar insurance policies being considered by a client, and comparing different Medicare Advantage plans. It can include any

mention of "Medicare Advantage" by the client or the need for assistance on any of the expanded health plan choices including Medicare Preferred Provider Organizations (PPOs), Medicare Private Fee-For-Service Plans (PFFS plans), or managed care plans.

Plan or benefit changes/non-renewals: includes any changes in a client's coverage due to plan non-renewals/terminations, changes in provider participation, changes in premiums, or changes in covered benefits.

Claims/billing: includes any problems with a Medicare Advantage plan covering a provider bill or with understanding the claims process that is not resulting in a review, reconsideration, or appeal. Helping a person sort bills and teaching them how to organize billings and claims papers fit into this category.

Appeals/quality of care/grievances: includes contacts associated with an appeal, quality of care complaint or grievance related to HMOs or other choices authorized under Medicare Advantage.

Medicaid (enrollment, eligibility, benefits)

All of these categories include helping someone understand what services are covered under a particular Medicaid program, answering general eligibility and enrollment questions, such as income and resource limits, and possibly helping clients complete enrollment forms.

QMB: includes discussion of eligibility for the Qualified Medicare Beneficiary program that pays for Medicare premiums, deductibles, and coinsurance.

SLMB: includes discussion of eligibility for the Specified Low-Income Medicare Beneficiary program that pays for the Medicare Part B premium.

QI: includes discussion of the Qualifying Individual program that pays for the Medicare Part B premium.

Other Medicaid (some of these may not apply to all states): includes discussion of the Regular Medicaid program, Medicaid for Aged or Disabled, Medically Needy

Medicaid, dual eligibility, LTC/home & community-based waivers, nursing home/spousal impoverishment, or Supplemental Security Income (SSI).

Medigap/Supplement/SELECT

Enrollment, eligibility, comparisons: includes contacts associated with explaining Medicare supplement coverage, answering questions about eligibility and enrollment, comparing policies, or providing information to help someone make a decision on the best policy to meet their financial needs.

Change coverage: includes discussion of the way a client can secure comparable or better insurance coverage, reduce coverage, cancel coverage, or not purchase unnecessary insurance. This also includes discussion of the Medicaid suspension option, which allows for the discontinuation of Medicare supplement premiums.

Claims/appeals: includes problems with Medigap covering a provider bill or with understanding the claims process. This section also includes contact associated with a review, reconsideration, or formal appeal regarding a Medigap decision or finding.

Other

Long-Term Care: May include explaining long-term care insurance; discussing eligibility; reviewing policies; providing someone with the information necessary to make a decision about whether or not to purchase a LTC policy; discussion of the way a client can secure comparable or better insurance coverage, reduce coverage, cancel coverage, or not purchase unnecessary insurance; and claims/appeals.

Medicare Fraud/Abuse: may include any problems associated with unethical, illegal, or abusive sales practices by a provider, an insurer, insurance representative, or managed care sales representative in regard to selling a client insurance policies or health plans. If a complaint based on abuse or fraud is filed, this category should be checked also.

Military health benefits: may include explaining military health benefits, comparing them to a Medicare Supplement or referral to a Military Retiree Benefits

Information Officer/program. A retiree may have health benefits through the military, including VA benefits or TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) coverage.

VA Benefits:

Employer health plan or FEHB Program: (Federal Employee Health Benefits Program): may include explaining an employer group plan or federal employee health plan, comparing one to a Medicare Supplement, or assisting a client with filing a claim or appeal.

Health Care Savings Accounts:

Customer service issues/complaint: may include discussions with clients who experienced inadequate service when contacting an agency, such as Medicare, CMS, Social Security Administration, state Medicaid agency, or a Peer Review Organization. This may include receiving wrong information, not being treated courteously by a representative, or not receiving assistance with an issue with which a representative is expected to help them. This also includes problems associated with unethical, illegal, or abusive sales practices. This does not include claims issues.

Other: includes any other type of assistance provided by the counselor which is not listed within the six major topic areas, such as ERISA (Employee Retirement Income Security Act of 1974), free care, or state specific topics. This can be written in on the blank line provided.

Optional Notes

Note that jotting down additional notes is for the benefit of the counselor only. This information will not be entered or uploaded to shiptalk.com, nor will it be used in any way by CMS. This suggestion is for the convenience of the counselor.

This can include information helpful to the counselor or coordinator such as a summary of the question or problem that the client described to the counselor,

the type of insurance coverage and policy numbers if needed for counseling purposes; what action was taken by the counselor and the outcome or resolution to the problem; referrals to other agencies; whether materials were mailed to the client; and status of the contact.

Furthermore, if a client specifies the exact dollar amount of savings associated with a particular issue checked in Section 3, then the counselor could use this space to provide the amount of dollar savings. Report this amount as given to you by the client (i.e. monthly or annually). No calculations are necessary.

Extraordinary Client Savings

Instructions for counselors to summarize extraordinary savings to clients:

If:

1. A client specifies the exact dollar amount of savings associated with discussion of a particular topic with the counselor (no calculations necessary by counselor), AND
2. This amount is $10,000 or more, AND
3. The counselor is reasonably sure that the discussion did in fact lead to this amount of financial savings for the client; then counselors should attach a separate page to the client contact form to summarize this case as part of their "optional notes".

This summary should include:

- Summary of the question or problem that the client described to the counselor;
- What action was taken by the counselor;
- Outcome or resolution to the problem; and
- Status of the client contact.

SHIP project directors should report these cases in the narrative portion of the Resource Report (Section 8).

OMB No. ____-___

State Health Insurance Assistance Program (SHIP) Client Contact Form (_ _)

Counselor Name:

Counselor Zip Code:

Type of Client/Assistance Requested by: (check all that apply)
- ❑ Beneficiary (self)
- ❑ Couple
- ❑ Caregiver (family member, conservator)
- ❑ Agency

How Did Client Learn About the SHIP: (check one)
- ❑ CMS (1-800-Medicare, www.Medicare.gov, Medicare & You, CMS mailing)
- ❑ Presentations/Fairs
- ❑ State-specific mailings/brochures
- ❑ Agency (senior org, disability org, Social Security)
- ❑ Friend/Relative
- ❑ Media (PSA, poster, ad, newspaper, radio, etc.)
- ❑ Other: _____

Date of Initial Contact:
__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:
- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:
_____ hours _____ minutes

Date if Multiple Contact:
__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:
- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:
_____ hours _____ minutes

SECTION 1 – BENEFICIARY INFORMATION

Beneficiary Name:
_____ First _____ Last

Beneficiary Zip Code:

Representative Name (if applicable):
_____ First _____ Last

Beneficiary Telephone #:
(__ __ __) __ __ __ - __ __ __ __

SECTION 2 – BENEFICIARY DEMOGRAPHICS

Age:
Date of Birth: __ __ / __ __ / __ __ __ __ OR
month / day / year
- ❑ Under 65 years
- ❑ 65 – 74
- ❑ 75 – 84
- ❑ 85 or older
- ❑ Not Collected

Monthly Income:
- ❑ Below 150% of FPL
- ❑ At or greater than 150% of FPL
- ❑ Not Collected

[$_____ = 150% FPL]

Race/Ethnicity:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Not Collected

Gender:
- ❑ Female
- ❑ Male
- ❑ Not Collected

Disabled:
- ❑ Yes
- ❑ No
- ❑ Not Collected

SECTION 3 – TOPICS DISCUSSED (check all that apply)

Prescription Assistance:

Medicare Prescription Drug Coverage (PDP/MA-PD):
- ❑ Plan eligibility, benefit comparisons
- ❑ Low income subsidy - eligibility, benefit comparisons
- ❑ Enrollment / application assistance
- ❑ Claims / billing
- ❑ Appeals/quality of care/grievances

Other Sources of Prescription Drug Coverage/Assistance:
- ❑ State Pharmacy Assistance Program
- ❑ Union/Employer plan
- ❑ Manufacturers Assistance Program
- ❑ Discount plans
- ❑ Other: _____

Medicare (Parts A and B):
- ❑ Enrollment, eligibility, benefits
- ❑ Claims/billing
- ❑ Appeals/quality of care/grievances

Medicare Advantage (PPO, PFFS, specialty plans, managed care):
- ❑ Enrollment, disenrollment, eligibility, comparisons
- ❑ Plan or benefit changes/non-renewals
- ❑ Claims/billing
- ❑ Appeals/quality of care/grievances

Medicaid (enrollment, eligibility, benefits):
- ❑ QMB/SLMB/QI
- ❑ Other Medicaid

Medigap/Supplement/SELECT:
- ❑ Enrollment, eligibility, comparisons
- ❑ Change coverage
- ❑ Claims/appeals

Other:
- ❑ Long-Term Care
- ❑ Medicare Fraud and Abuse
- ❑ Military Health Benefits
- ❑ VA Benefits
- ❑ Employer Health Plan or Federal Employee Health Benefits Program
- ❑ Health Care Savings Accounts
- ❑ Customer Service issues/complaint
- ❑ Other: _____