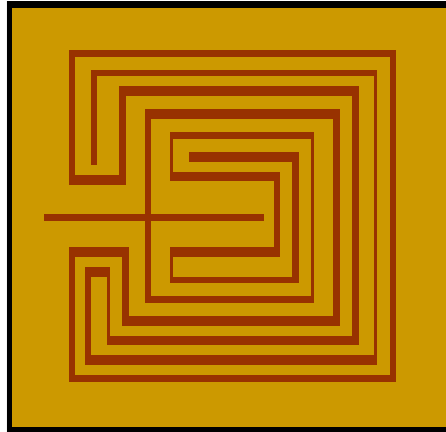


A Definitive Three Step Approach to  
Choosing The Best Medicare Plan

(for you)

While Avoiding The Pitfalls



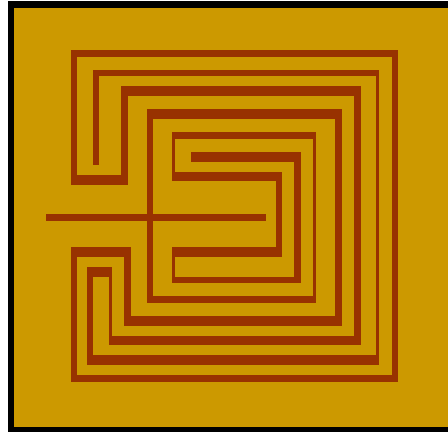
Presented to you by:  
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For more information visit my website: <http://www.yourhealthplanadvisor.com>  
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Medicare has dozens if not hundreds of publications containing thousands if not millions of pages of information. I have tried to boil it all down to just a few pages and three simple steps. However, there is much more information that you may need to know. Visit my website or give me a call and we'll discuss your situation. There is no obligation or cost on your part.

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**“Your guide through the Medicare Maze”™**

# MEDICARE IS CONFUSING

**Do you find Medicare to be confusing?  
Most people do.**

Before you decide which plan to purchase you must arm yourself with as much knowledge as possible about what types of plans are available, such as what are the different types of plans and how does each type operate.

Medicare has particular rules and regulations that each plan must follow, but that doesn't mean that each company is the same. There can be big differences between plans. To make it even more confusing, the best plan for your spouse or your neighbor isn't necessarily the best plan for you. Many people who say "John Doe next door has XYZ plan. If it's good enough for him it's good enough for me" are doing themselves a disservice.



This white paper will explain in basic terms and easy to understand language how to select a Medicare plan. In most counties there are dozens of options – we pick the best one for you using the following three step approach.

# STEP ONE

## Analyzing your Part D drug coverage.

This step is the most important step as well as the most difficult. It is also the most difficult to explain and understand. This is the first thing I do for my clients and this is the first thing you must do - because drug costs can be one of the biggest differences between plans. This step will eliminate many of the plans that are more expensive or are unsuitable, leaving the more cost effective plans still in the running.



You get drug coverage either through a stand-alone drug plan or through a Medicare Advantage plan with drug coverage. To do an accurate and effective analysis you'll need to go through the following four steps.

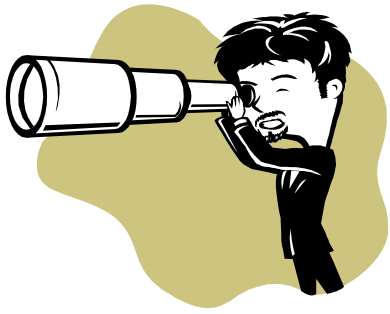
1a. Find out what tier levels your medications are placed with each company. Just because you have a generic doesn't mean that drug is always on Tier 1. I'll explain the tier levels later. To keep your options open you'll want to do this with each plan. So if you live in Maricopa County you'll have to check the 25 drug plans and the 25 Medicare Advantage plans that have drug coverage.

1b. Find out how much your medication will cost each month. Co-pays will be different with each company. This year a "non-preferred" generic drug could run from \$5 to \$90 per month with the different plans. There are also have plans that charge 20% to 67% so to figure your costs you'll need to find out "20% of what"?

1c. Find out when you are going to go into the 'donut hole', and what your medications will cost during that time. Your cost will be different with each company because you pay a percentage of what the company pays during this time, and each company will negotiate a different cost for each drug.

1c.1 – here is a quick explanation of the 'donut hole'. A more detailed explanation along with an illustration follows in the next section. After you and your drug company together has paid (in 2011) \$2840 in total drug expenses you go into the donut hole, where you pay 93% of the negotiated cost of your generic medication and 50% of the cost of your brand name medication.

1d. Find out if and when you'll come out of the 'donut hole', and what they'll cost during the catastrophic coverage. With all plans you pay the greater of \$2.50 for generics, \$6.30 for brand, or 5%. Again, you need to know "5% of what".



You can search for all of this information on the Medicare website, on the website of each company, or through your agent. For the websites you'll need to follow the prompts on each separate site. This can be daunting even if you are a computer ace, but can be even more so if your computer experience is low and can take you several days. A good agent that works with all of the major companies will have the experience and knowhow to get you this information in only an hour or two. The websites can also be difficult to navigate and hard to understand.

## Pitfalls:

Is your medication on the formulary? Most people think that a medication not being covered is a bad thing. However, if the drug is not covered the cost is not applied toward the donut hole, which can be a good thing. This information is revealed to you when you analyze your medications. Sometimes, a drug not being on the formulary, while costing more in the beginning, will keep you from going into the donut hole. Going into the donut hole will cause all of your other medications to be more expensive.



Are there quantity limits? If you are taking 2 pills per day but the insurance company will only pay for one you may have a problem.



Is there step therapy? Step therapy means the insurance company will require you to try a lower cost medication first before they'll cover the higher cost drug.

Is there pre-authorization needed? This means you must ask your insurance company to cover the cost before you start taking the drug. This can be a big pain, especially if you are already taking that drug when you sign up for the plan.



Exceptions can be made. In general, you have 30 days after the effective date to ask the company for an exception to the above limitations. As a rule, though, exceptions are seldom granted.

The difference in medication costs that YOU would pay between companies in a year can be as little as a few dollars to over \$40,000 in extreme cases.

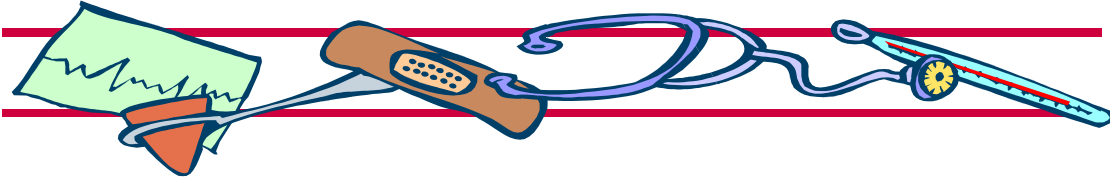
A plan with a higher premium does not necessarily mean that your drug costs will be lower than a plan with a lower premium.

A plan with a higher premium does not mean you get better coverage than a plan with a lower premium of the same company, it just means you have different coverage and the plan is set up differently. For example, one of your medications may be in the formulary with one plan while with another plan from the same company your medication may not be on the formulary. So don't assume that your meds are covered until you've checked each plan available.

Do not be afraid of plans with deductibles. Many times your total costs over the course of a year will be less even paying the deductible.

If you don't get Part D coverage when first eligible you may have penalties in the future.

Now, for those who'd like a better understanding of Medicare drug coverage please read the next few paragraphs. For everyone else you can proceed to step two.



**HERE IS A MORE DETAILED EXPLANATION OF PRESCRIPTION DRUG COVERAGE**

Medicare requires you to have a Part D drug plan or face future monetary penalties and other restrictions. The penalty is you will pay 1% of the national premium average for *each month* you were eligible for drug coverage but did not have such coverage. Also, if you don't get the coverage when first eligible the only time you can purchase coverage is during open enrollment, which this year is from October 15 – December 7 for a January 1 effective date.

Medicare has standard guidelines concerning drug coverage. Medicare states that each drug plan must cover at least the standard benefit “or its actuarial equivalent”. The “actuarial equivalent” is one place where companies differ. However, the insurance companies can and do offer enhanced coverage that is “better” than standard for a higher premium. What is better, though, will depend upon what medications you are currently taking.

The Medicare guidelines allow for plans to have a deductible, which can increase each year. In 2011 the deductible is \$310, the same as last year. After you pay the deductible you go into what is called the “initial coverage” period, where you pay approximately 25% of the cost and

the insurance company pays 75%. This coverage period last until both you and the insurance company has paid \$2840. Your dollar share during this period is approximately \$632.50. You then go into the

|   |            |
|---|------------|
| 95% Plan Contribution 'CATASTROPHIC COVERAGE' | 5% co-pay  |
| 50% - 93% Enrollee Payment 'DONUT HOLE'       |            |
| 75% Plan contribution 'INITIAL COVERAGE'      | 25% co-pay |
| Deductible                                    |            |

coverage gap, which is commonly known as the “donut hole”. During this time, you are paying 93% of the *negotiated* cost of your generic medication and the insurance company is paying 7%. For brand name drugs you are paying 50% of the *negotiated* cost while the pharmaceutical companies are paying 50%. Your exposure in the donut hole is the total amount paid for your medications – or \$3607.50. After the donut hole you go into catastrophic coverage where you pay approximately 5%.

Drug plans use co-pay tiers, which is a set amount for each prescription. The “set amount” can be either a flat dollar amount or a percentage, and any one plan may have both. Most plans have four tiers but I’ve seen anywhere from three to six. Here is a common example:

- Tier 1: Generic drugs
- Tier 2: Preferred brand-name drugs
- Tier 3: Non-preferred brand-name and Non-preferred generic drugs
- Tier 4: Specialty, injectables, and some generics

Drug plans also use a formulary, which is a list of drugs covered by the plan. They can also require you to try lower cost drugs in some cases. They may require you to get prior authorization before the plan will cover a drug. They may have a limit on the quantity that you can use daily. What makes it more difficult is any particular drug may be treated differently with each company.

You may qualify for Extra Help with your prescription drug costs. This extra help is based on income. To see if you qualify you can call:

- Medicare at 1-800-MEDICARE (1-800-633-4227)
- Social Security Administration at 1-800-772-1213
- AHCCCS at 602-417-4000 toll free 1-800-654-8713
- or use the form provided by each company when you enroll

# Step Two

## Finding out what plans your doctor accepts.

This is usually the easiest step. First, you need to make sure your doctor accepts Medicare. Many do, but not all. Then, you can either ask your doctor which companies they accept or you can look on the website provider list of each company.

### Pitfalls:

The doctor may stop taking that plan in the future. They can go on and off network plans with little notice. They can go on and off of Medicare. Since the Medicare reimbursement rates are not keeping up with medical inflation some doctors are either limiting new Medicare patients or are dropping out of the program entirely.



# Step Three

## Deciding upon which type of health plan to purchase.

You have three options.

1. Original Medicare
2. Medicare Supplement
3. Medicare Advantage

The first Option - just Original Medicare. You can visit any doctor that accepts Medicare anywhere in the U.S.



### Pitfalls with Option 1:

You will be responsible for paying the \$1132 Part A per occurrence deductible, the \$162 Part B annual deductible, and the 20% co-insurance. Also, if your doctor doesn't accept assignment you'll be responsible for the 15% Part B excess.

There is no cap to your costs. One big example is the Mayo Clinic. If you have a \$100,000 medical bill there you could be responsible for up to \$35,000.

Medicare has limits of coverage. For example, Medicare does not cover dental.

The second option – Medicare Supplement. You can visit any doctor that accepts Medicare, anywhere in the U.S. If you get a comprehensive Supplement plan when you go to the Mayo Clinic in the above example you will have \$0 costs for Medicare Approved procedures. There are several different plan options, all with varying coverage. They're known as Plans A, B, C, D, F, G, K, L, M, N. There are also select C, select F, and high deductible F plans available. Not every company has each plan type.

## Pitfalls with Option 2:

None of the Medicare Supplements have drug coverage, so you do need to purchase a separate stand-alone Part D drug plan if you want the coverage and to avoid the penalty.

Supplements do not cover anything over and above what original Medicare covers except for an additional 365 hospital days.

Premiums can be too much for some people. Premiums will increase each year based on age.

You'll need to learn about each Plan letter and what they cover. Most people get Plan F but if you are looking to save premium dollar you can choose one of the other plans that have a lower cost and fewer benefits.



The third Option – Medicare Advantage Plan. This option can be very confusing, depending upon your state and county, and you need to learn many acronyms. Here is a listing and a small, incomplete description of each acronym:

HMO – Health Maintenance Organization. There is a network of doctors. You must select a primary care doctor. You cannot go to a doctor that is not in the network unless it is an emergency or urgent care situation. You must get a referral from your primary care doctor to visit a specialist.

PPO – Preferred Provider Organization. This type of plan has a network of doctors, the “preferred providers”. However, you can go to a doctor that is not in the network without a referral. If you do, though, the amount of money that you pay will usually be higher. How much higher will depend upon the plan and the particular situation.

HMO/POS – an HMO with a Point of Sale option. This plan gives you the option to go to a provider that is out of network for certain procedures. You generally will need to get approval from the plan and referrals to use out of network providers.

PFFS – Private Fee For Service. This is based off of Original Medicare, which is also a Fee For Service. There are non-network PFFS plans and there are network PFFS plans. With the non-network plans you can visit any doctor that accepts Medicare. However, the doctor must be willing to accept the plan and can decide on a case by case basis whether or not to accept each plan. Even if they accept the plan today doesn’t mean they’ll accept the plan tomorrow. If they accept the plan for you that doesn’t mean they’ll accept the plan for your spouse. The network plans operate similar to the PPO plans mentioned above. Because of the restrictions and confusion most of the PFFS plans are going away in all except the very rural areas. If you want my opinion on how Congress messed up with these plans give me a call and I’ll be happy to explain.

SNP – Special Needs Plans. These plans are specifically designed for people with certain qualifying illnesses, such as diabetes, chronic heart failure, cardiovascular disease, or chronic lung disorders. They can be set up either as an HMO or a PPO. They will give you special benefits that are helpful with your particular health condition. Most plans offer you some basic transportation to approved locations, such as a doctors office or pharmacy.

Dual – a SNP for people that have both Medicare and Medicaid. If you are on full AHCCCS you can enjoy the benefits of a Medicare Advantage plan without most of the normal costs, since Medicaid pays any premium and co-pays. You'll also have drug coverage at a reduced co-pay. These can be set up either as an HMO or a PPO but currently in Arizona all plans are HMO's.

There are also PACE, MSA, and Cost plans as well as an occasional demonstration plan but these are not currently available in Arizona.



## Pitfalls with Option 3:

The pitfalls can depend upon the type of plan that you get. If you re-read the above descriptions of the plans you'll get an idea of some of the pitfalls.

If you want the freedom to choose your own doctor an HMO plan is not for you. You also must select a primary care doctor with an HMO. The PPO plans can be more expensive than the HMO. The PFFS plans are being stripped of their effectiveness and at this writing I'm not sure what they'll look like in the future. SNP plans can actually be more expensive for some people in some cases.

You are generally locked into these plans for an entire year, except for the SNP or Dual plans. The annual enrollment period for 2011 is October 15 through December 7 for a January 1, 2012 effective date. Doctors in the networks can change at any time. This means if your doctor decides to leave the network in February you will have to change doctors until you can change plans.

Plans have an annual contract with Medicare. This means that they can and do change each year. They can also stop the plan completely. They can bring on new plans and discontinue old plans. This means you need to check each and every year to make sure that your plan is continuing and that you have the best plan available.

Medicare Advantage plans generally have drug coverage included. If you get a PFFS or an MSA plan without drug coverage you have the option to purchase a separate stand-alone drug plan. However, and this can be a big pitfall so I'll highlight it:

**\*\*If you get an HMO or a PPO plan without drug coverage you are not allowed to purchase a stand-alone drug plan\*\*.**

If you try to get a drug plan when you have an HMO or PPO without drug coverage you will be enrolled in the drug plan but you will be **automatically** dis-enrolled from the Advantage plan. Conversely, if you have a stand-alone drug plan and try to enroll in an Advantage plan without drugs you will be **automatically** dis-enrolled from the drug plan. Please give me a call if you don't understand this.

Premium, co-pay, and drug costs may be different on each plan from the same company. So if you have a company you like, but want to switch to a plan with a lower premium of that same company, you'll want to check the drug coverage. Many times a lower premium plan will have a higher co-pay for your drugs.

Some big name doctors and medical clinics, such as the Mayo Clinic, do not accept ANY Medicare Advantage Plans. So if we go back to the example of several pages ago concerning the Mayo Clinic neither Medicare nor the Medicare Advantage plan will pay anything. You will be responsible for the full charges.

## SUMMARY

I hope this paper helps you in your selection of the best Medicare plan.

To review, here are the three steps:

Step one – analyze your prescription coverage – find the most cost effective plans

Step two – check to see what plans your doctor will accept

Step three – decide which type of plan to get.

If you have any questions or if you need assistance anytime during your research please don't hesitate to give me a call. You can also shoot me an email at

[arnold@yourhealthplanadvisor.com](mailto:arnold@yourhealthplanadvisor.com)

I would also like the opportunity to earn your business. Even if you've made a final decision as to which plan and company to purchase without my assistance (other than this white paper) if you sign up through me you'll have someone who can make sure you actually get enrolled. You'll have someone who will check on the application daily to make sure it is being processed and to smooth over any bumps that may occur. There will be no extra fees signing up through me. One additional plus – I have one phone line. When you call me you are calling direct. You will not have to listen to any menu options only to find the option you really need is not available.