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# MEDICARE AND MANAGED CARE

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**M**edicare is a federal health insurance program administered by the Health Care Financing Administration, a part of the U.S. Department of Health and Human Services. Enrollment in the program is handled by the Social Security Administration. Enrollees have options on receiving care – “pay per visit” coverage under the original Medicare plan, and newer options for managed care plans under the Medicare+Choice plan.

People 65 and older, individuals of any age with permanent kidney failure, and certain disabled people under 65 are eligible for Medicare. People under 65 who are receiving Social Security or Railroad Retirement benefits are automatically enrolled in Medicare, and receive a Medicare card in the mail three months before their 65th birthday. Others that need to apply for Medicare should contact their local Social Security office or the Social Security Administration.

Medicare coverage has two parts, Part A and Part B. Part A is hospital insurance, provided free of charge to most Medicare beneficiaries. Part B, medical insurance, is optional and is offered to all beneficiaries when they enroll in Medicare. Part B helps pay for doctor’s bills and other medical services, both inside and outside of the hospital. A monthly premium (\$45.50 in 2000) must be paid for Part B benefits. Most Medicare beneficiaries have the monthly premium for Part B deducted from their monthly Social Security benefit payment. Beneficiaries can get help in paying Medicare premiums and out of pocket expenses through programs such as QMB (Qualified Medicare Beneficiary program), SLMB (Specified Low-income Medicare Beneficiary program), QI-1 and QI-2 (Qualified Individual programs). Contact Medicare or the State Health Insurance Assistance Program for more information.

## ORIGINAL MEDICARE PLAN

Under the original Medicare plan, Medicare generally pays 80% of all allowable charges for medically necessary services. Many providers accept Medicare’s approved amount as full payment. The patient is still required to pay any coinsurance amount and any unmet deductible. However, beneficiaries treated by physicians who do not accept assignment pay charges up to 15% in excess of the allowable charge by physicians.

## MEDICARE+CHOICE

With the Medicare+Choice plan, seniors in most parts of the country can choose to join a local health maintenance organization (HMO) or other managed care plan to receive all of their Part A and B benefits.

“Managed care” is a catchall term for health plans that are organized to provide cost savings for consumers by structuring avenues of access to health care. In an HMO, members pay a monthly premiums that covers all or nearly all of the cost of their health care. Each HMO has a network of providers to choose from. For seniors with Medicare, choosing an HMO can provide significant cost savings, as well as benefits, such as prescription drug coverage, that are not provided by the traditional Medicare plan.

Seniors enrolled in Medicare+Choice still pay the part B monthly premium (\$45.50 in 2000), and may have to pay a separate monthly premium to the HMO. There may be small co-payments (generally \$5-\$20) required for doctors’ visits and prescription drugs.

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## There are important differences between an HMO and original Medicare coverage:

- Seniors must choose from the HMO's list of doctors, hospitals and pharmacies in order to receive full coverage. Seniors may go outside of the plan, but will pay a larger percentage of the cost or the entirety of the cost.
- Managed care plans can decide once a year to change coverage, change premiums, or discontinue offering service to Medicare beneficiaries. Beneficiaries can return to the original Medicare program at any time.
- Complete coverage is only available in a specified area. Seniors who travel frequently or have more than one residence may have to pay more for care received outside of the HMO's coverage area.
- There are lower out of pocket costs and less claims paperwork with HMO plans.
- Patients generally receive coverage for specialist care after receiving a referral from their primary doctor with HMO plans.

## TIPS TO REMEMBER

- Ask your current doctor if s/he participates in HMOs that offer coverage to Medicare recipients.
- If more than one organization offers these plans in your area, compare premiums and other out of pocket costs, as well as the benefits each plan offers.
- Make sure to ask questions about any portions of your HMO policy that are unclear. HMOs are very different from traditional health plans, and mistakes such as failure to get pre-certification for certain procedures may mean that you will be denied coverage.

## FOR MORE INFORMATION ON ORIGINAL MEDICARE AND MEDICARE+CHOICE:

- **THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)** is the federal agency that administers the Medicare program. For more information on your benefits and responsibilities, contact them at 800-MEDICARE (800-633-4227), [www.medicare.gov](http://www.medicare.gov), or 7500 Security Blvd, Baltimore MD 21244. Contact the Medicare hotline, or [www.medicare.gov/comparison](http://www.medicare.gov/comparison), for information on different companies that offer Medicare+Choice plans.
- **YOUR STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)** can also provide information on Medicare and Medigap options.
- **THE SOCIAL SECURITY ADMINISTRATION** handles enrollment in the Medicare program. Call your local office, or contact 800-772-1213, or [www.ssa.gov](http://www.ssa.gov).

Individual circumstances vary. Check with the appropriate professional regarding your options.



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