

FROM STATE SENATOR LIZ KRUEGER

Dear Neighbor,

All of us are deeply affected by access to health-care. We receive our care in many settings and there are a range of sources for payment. While providers may be covered by private insurance or government sponsored insurance, i.e. Medicare and Medicaid or a combination of both there are regulations, laws and public agencies that oversee their operation. Information about many of them is included here.

Confusion is widespread. Rapidly increasing medical costs, insurance rate increases, rising deductibles and reduction in covered services abound. We are living in a time of healthcare coverage chaos. Universal, single payer coverage is a policy that I have long believed must be intelligently approached and implemented as soon as possible.

Please save this resource, keeping it with your other health insurance information. If you need further information, please contact my District Office at 212-490-9535 and we will be happy to help.

Sincerely,



Liz Krueger

Are There Patients' Bills of Rights?

Yes. There are two. The state and federal governments require all hospital patients in NYS be given the Patient Bill of Rights. It includes the rights of each NYS hospital patient, a glossary which defines commonly used hospital terms and copies of documents the hospital is required by law to give its patients. NYS has also developed a set of laws that help keep the rights of managed care patients safe. The basics of these laws are in the Managed Care Bill of Rights. You can get copies of either of these documents by contacting my office at 212-490-9535.

I. INSURANCE REIMBURSEMENT

Always check with the NYS Insurance Department at 1-212-480-6400 before purchasing a health insurance policy to confirm that the health plan is licensed to do business in New York.

Who should I call if I am having difficulty with my health insurance benefits?

Checking your plan's policy manual for its appeal process would be the best place to start. If you need further clarification, call your health plan's customer service representative. If you have exhausted all contacts at your health plan's appeal process and are still having difficulty, you can complain to an outside agency. First, call the Attorney General's Health Care Helpline at 1-800-771-7755 to report any problems about any health insurance plan payment issues.

How long should it take your health plan to pay claims?

New York's Prompt Pay Law requires health plans to pay claims within 45 days of their receipt. If the health plan believes that it is not responsible for paying any or all of a claim, it must notify the consumer in writing within 30 days of receipt of the claim, providing specific reasons why it is not responsible for payment or requesting additional information in order to determine its liability for the claim. If the health plan does not promptly pay claims, it is subject to fines and must pay interest on late payments. You can call the Attorney General's Health Care Helpline at 1-800-771-7755 with any problems or questions.

What are the rules for emergency room services coverage?

Under New York's "Prudent Layperson" standard, health plans must cover emergency

claims when the individual has symptoms that an ordinary person would consider a serious health risk even if the final diagnosis is not as severe as the patient originally thought. Additionally, health plans cannot ask enrollees for pre-authorization before seeking emergency care nor are enrollees restricted in the hospitals they may go to. Notify the plan after you have sought emergency care and especially if you are admitted.

What if my health plan won't cover a pre-existing condition?

State and federal law require that a pre-existing condition be covered as long as there was no break in coverage of 63 or more consecutive days between the end of membership in the prior plan and the start of membership in the current plan. If there has been a break in coverage and a pre-existing condition exists, health plans can impose a waiting period, that does not exceed 12 months after the enrollment date. When changing health plans, consumers should make sure to get a "certificate of coverage" from former health insurers. This certificate will help determine how much time should be credited towards any pre-existing condition waiting period.

Can pharmacists in New York State substitute a less expensive generic equivalent for a brand name drug?

If the doctor does not check the box that says "dispense as written" then the pharmacist can give you a generic. Pharmacists cannot give you a generic if there is no FDA approved generic equivalent.

II. APPEALING A CLAIM OR A HOSPITAL DISCHARGE

Can I appeal a health care plan denial of a claim?

Yes. Always appeal any denial of coverage of service that you and your doctor think is necessary. People who do appeal often win additional coverage. Check your policy manual for your health plan's appeal process, but the following steps are generally a part of the process. First, since you have a right to a written explanation of denial, request one from your health plan. If you don't receive it, demand it, since you will need it to write your appeal. You can also ask your doctor to assist you by asking him/her to write a letter explaining why you need the care. Having your doctor call the health plan's medical director can also help in your appeal. Make sure to follow any time lines for submitting your appeal and send it by certified mail with a return receipt requested in order to create a record of its mailing. Be persistent; keep calling to find out the status. Document

the dates, times and people with whom you spoke and keep copies of any documents or letters you send to the health plan. For help with your appeal you can call the Attorney General's Health Care Helpline at 1-800-771-7755.

What is the hospital discharge appeal process?

All patients receive a Notice of Discharge along with an explanation of their appeal rights 24 hours before they are discharged. If the hospital is preparing to discharge you before you feel you are ready, there are several steps you can take to get an independent review of the hospital's decision. Please contact my office if you would like a copy of these procedures.

III. PRIVACY RIGHTS & ACCESS TO RECORDS

What is HIPAA and how does it affect me?

HIPAA or the Health Insurance Portability and Accountability Act of 1996 is a set of regulations that governs the privacy of a patient's individually identifiable health information. Patients are asked to sign the HIPAA notice each time it changes.

Do I have the right to view and obtain my medical records?

Yes. NYS law provides for the automatic right of consumers and other qualified individuals (e.g. parents, guardians or consumers' attorneys) to view and obtain copies of medical records within 30 days of a request. The law also restricts the cost of copies of records to 75 cents per page. Reproducing X-rays or other images may be charged at their actual cost. Individuals may not be denied copies of their records because they cannot afford to pay for them, but they may be asked to prove their inability to pay. Certain medical information can be restricted such as a physician's notes and observations. Consumers should request the medical records in writing including the period of time for which the records are being requested and a return address. The request should be signed by the patient or other qualified individual. If the request is denied, consumers can appeal the decision with the NYS Department of Health at 1-800-804-5447.

IV. MEDICARE & MEDIGAP POLICIES

Are there changes happening to the Part B premiums?

Yes. Beginning in 2007, as outlined in the Medicare Modernization Act, part B premiums will begin to be tied to income. The standard Part B premium in 2008 is \$96.40. Individuals with incomes greater

than \$80,000 will pay between \$105.80 and \$162.06 this year. This is part of a phase in that will eventually result in the highest income beneficiaries paying for the actual cost of their Part B plan. As premiums rise we need to be watchful that the results of these increases do not result in seniors dropping their Part B coverage entirely or feeling they have no choice but to abandon traditional Medicare and join a Medicare Managed care program.

Are there penalties for not taking Medicare Part B?

It depends. While Part A is generally free (if you or your spouse have worked 10 years or more in the United States), you pay a monthly premium for Part B (\$93.50 in 2007). If you are eligible for Medicare when you turn 65 and you have Social Security benefits or have a disability and have been receiving Social Security Disability Insurance for 24 months, you will be automatically enrolled in Parts A and B. You may choose not to enroll. If you delay enrolling in Part B, you may have to pay a penalty of 10% of the Part B premium for each year that you delay. If, however, you are working and you have employer coverage, or are covered through your spouse's employer's health plan and lose that coverage you can enroll in Part B within eight months without penalty.

Can I get help paying for Medicare part B?

Yes, if you are single and make less than \$1,169, or a couple making less than \$1,560 per month, there are programs that can help you pay your Medicare part B premium. If you pay premiums for additional health coverage, like EPIC or a Medigap policy, you can deduct these from your monthly income when calculating your eligibility. For more information, or to be screened for a Medicare Savings Program call the Medicare Rights Center at 888-795-4627 or my office at 212-490-9535.

What is a Medigap Policy?

A Medigap policy is a health insurance policy with a separate premium sold by private insurance companies to fill the "gaps" in Original Medicare (you get your benefits from the government and have not signed up for a private plan like an HMO or PPO). Medigap policies help pay some of the health care costs that original Medicare doesn't cover. If you are in Original Medicare and have a Medigap policy then Medigap will pay most, if not all, of your Medicare coinsurance and co-payments. Currently there are 12 standardized Medigap plans called "A" through "L" each of which has a different set of benefits. Plan "A" offers the fewest benefits and is usual-

ly the least expensive. Plans that offer more benefits are generally more expensive. Each category of plan offers identical benefits; premiums may vary between insurers. In New York, it is possible to switch standard Medigap policies; if switching companies you may do so at anytime. If you are switching plans within one insurance company, you can only switch during the period when the company allows it.

Does Medigap insurance cover pre-existing conditions?

Yes. Medigap insurance does cover pre-existing conditions, but you may have a waiting period of up to six months for coverage of services related to that condition. You will not have a pre-existing condition waiting period if you had coverage from another creditable insurance plan for at least six months prior to purchasing a Medigap policy and did not go more than 63 days without coverage.

What if I have a complaint about my Medigap Policy?

Medigap insurance is governed by NYS and Federal law. If you have a concern or a complaint about your Medigap Policy first contact Attorney General's Health Care Helpline at 1-800-771-7755 and explain the issue.

Can I get help to pay for my Medical and Hospital Costs?

Yes. If you have limited income and savings, you may be able to get government help through Medicaid (Medical Assistance Program) which requires you to meet income and asset limits. You can call the Medicare Rights Center at 1-212-869-3850 to find out the Medicaid rules or 311, which will provide you with information regarding Medicaid and directions to an office where you can apply for Medicaid. You can also find out about Child Health Plus and Family Health Plus, these are programs that provide health care benefits to low income individuals, parents with minor children and children by calling 311 or the Medicaid Helpline at 1-888-692-6116. Small employers, sole proprietors and individuals may call Healthy New York at 1-866-432-5849.

What is COBRA and can I have Medicare too?

COBRA, a federal law, lets you keep your employer group health plan coverage for 18 months if; your covered spouse has passed away, you have lost your job, your work hours have been reduced, you left your job voluntarily, or divorced. If you are eligible for Medi-

care you can be eligible for COBRA only after you already had enrolled in Medicare. Medicare acts as the primary payer and COBRA as the secondary payer. It depends upon your health care needs as to whether you should have both forms of coverage because having both can be expensive. If, however, you already have COBRA when you become entitled to Medicare, your COBRA coverage will end on the date you become entitled to Medicare (unless you are entitled to Medicare because of End-Stage Renal Disease).

V. MEDICARE PART D

How can I get Medicare Prescription Drug Coverage/ Part D?

Beginning January 1, 2006, all Medicare Part A and/or Part B Policyholders were given the option of enrolling in a Medicare private prescription drug plan (Part D). The drug benefit is available:

1) If you have Original Medicare you can add on a "stand-alone prescription drug plan"; or

2) If you have a Medicare private health plan such as an HMO or PPO which would include all of your Medicare-covered services including the drug benefit

You can view and compare Medicare drug plans costs, covered drugs and pharmacy networks on the Medicare web site at <http://www.medicare.gov> or you can call Medicare at 1-800-633-4227. In order to enroll, you must get an enrollment form from the plan, complete it and return it to the plan. Do not give personal information by phone to unsolicited callers.

How much will my drugs cost with Medicare Part D?

The cost will depend on which plan you choose, drugs you take, and pharmacy you use. Each plan has its own list of covered drugs (formulary). You will probably pay a monthly premium, an annual deductible (\$265 maximum in 2007) and a portion of the cost of each prescription of a covered drug that you have filled. Once you reach a certain amount in drug costs (as determined by your plan) you will then have to pay 100% of the cost of your covered drugs for a period of time, known as the "doughnut hole." In all plans, once you have spent \$3,850 out of pocket for covered drugs in 2007 (not including monthly premiums, drugs not covered and/or for prescriptions not filled in network pharmacies) you will then have "catastrophic coverage." When you have catastrophic coverage, you will pay \$2.15 for generics and \$5.35 for brand names or 5% coinsurance whichever is higher. Note that

if you have not reached the \$3,850 maximum out-of-pocket expenditure by the end of each calendar year, your out-of-pocket expenses reset to \$0 and you will start the new year by meeting your deductible.

Can I Get Extra Help Under Medicare Part D?

Yes. If you are low income and have limited or no assets you may qualify for Extra Help which is federal assistance that helps with the costs of the Medicare drug benefit. If you want to enroll in Extra Help you can call the Social Security Administration at 1-800-772-1213. The Medicare Rights Center also has a new service called Linking Individuals in Need to Care and Services (LINCS) that helps New Yorkers with Medicare enroll in Extra Help. You can call LINCS at 1-888-795-4627 or the Medicare Rights Center Hotline at 1-800-333-4114 ext. 1 or 1-212-869-3850 for assistance

Can I still enroll in a Medicare Private Prescription Drug Plan if I missed the initial enrollment period?

Yes, if you didn't sign up during the initial enrollment period you may still be able to sign up during the Annual Coordinated Election Period which runs from November 15 to December 31 every year, but you may have to pay a premium penalty. The premium penalty is 1% of the average national premium for every month you delay enrollment and will be added to your monthly premium for as long as you have Medicare drug coverage.

How do EPIC and the Prescription Drug Plan/Part D work together?

EPIC is New York's senior prescription savings plan that can save you up to 70% on prescription drugs. Eligible seniors, over 65 - not on Medicaid - with an income below \$35,000 or \$50,000 for married couples, can enroll in EPIC. Currently, EPIC enrollees who qualify for "extra help" must return the "request for additional information" forms and will be enrolled in a part D plan based upon their drug and pharmacy usage. Those who do not qualify for "extra help" are not currently required to take a Part D Plan, however Governor Spitzer's proposed 2007 budget does mandate all EPIC enrollees join a Part D plan. For those who do enroll in both Part D and EPIC, any prescription costs not covered by Medicare will automatically be billed to EPIC by the pharmacy, including the Medicare deductible, co-payment, gap in coverage and non-covered drugs. EPIC's deductible plan enrollees can count the Medicare's drug plan's deductible (\$250), Medicare's coinsurance from \$250 to \$2,250 and coverage gap towards the EPIC deductible

amount. Additionally, both of EPIC's plans are considered "creditable coverage." Therefore, an EPIC recipient who does not enroll in Part D but decides at a later date to enroll in Part D will not be subject to penalty for late enrollment as long as they enroll in Part D within 63 days of losing EPIC coverage. Additionally, costs paid by EPIC will count toward the out-of-pocket expenses, thus enabling recipients to meet the catastrophic threshold sooner. Call 1-800-332-3742 to get an EPIC application.

VI. LIVING WILLS AND HEALTH CARE PROXYS

What are Advance Directives under New York State law?

Advance Directives is the term used for legal documents that ensure your health care wishes will be followed if you are unable to speak for yourself or should you become ill or injured for any length of time. Under NYS law, discussing your wishes in advance with family and friends is not enough, nor is assuming that someone you know and trust can automatically make decisions for you. Your treatment wishes will be followed if you complete a Health Care Proxy and Living Will. For more guidance about which documents to choose please visit <http://www.oag.state.ny.us/health/EOLGUIDE012605.pdf> or contact my office at 212-490-9535 for free copies of the forms.

How do I make my advance directives known?

- Make several photocopies of the signed forms;
- keep the originals in a safe but accessible place (not a bank safe deposit box);
- give copies to your health care agent, alternate agent, your attorney or other advisor, close family members and doctors;
- include information about the location of your Health Care Proxy or a Living Will in your wallet.

Are advance directives only for the elderly or chronically ill?

No. They are for everyone to help ensure that their health care wishes are followed if they become ill or injured for any length of time. It is a good idea to think about these issues before you are in a crisis situation.

VII. LONG TERM CARE

What is Long Term Care?

Long term care is a variety of services for people who have a chronic illness or disability at any age. These services, such as skilled nursing care based on your doctor's orders, occasional nursing and rehabilitative care based on your doctor's orders and performed by skilled medical per-

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SAVE THE DATE!
Senator Liz Krueger's Resource Fair for Seniors & Caregivers
Thursday, April 24th 1:30-4:30 PM
Temple Emanu-El One East 65th Street (at 5th Avenue)
 No RSVP Required
 Call (212) 490-9535 for further information



Health Care Update
 State Senator Liz Krueger's
 New York State Senate, Albany, NY 12247

sonnel, custodial care such as helping with bathing, dressing eating or taking medicine, may be given in a nursing home, adult home, assisted living, or at home..

What is Private Long Term Care Insurance?

The cost of long term care can vary depending on what kind of care you need, where you get the care and where you live. Medicare does not cover "custodial care." Most long term care is custodial care. Medicare does cover some limited costs for rehabilitation. If you are eligible, Medicaid will cover all long term care costs. Private insurance policies purchased through insurance brokers or agents can cover long term care needs, but vary widely in their costs. Your premium will be determined by age, health status and extent of the coverage you want. If you purchase a policy when younger, periodic reviews of your health needs and your policy should be done to make sure your policy still covers current and future long term care needs. Purchasing a Long Term Care policy is similar to purchasing any other kind of policy. It is important to compare policy benefits and costs between insurance companies.

What is The New York State Partnership for Long Term Care?

The New York State Partnership for Long Term Care ("The Partnership") is a program that combines private long term care insurance and

Medicaid to help New Yorkers prepare financially for nursing home or home care. The program allows New Yorkers to protect their assets while remaining eligible for Medicaid if their long term care needs exceed the period covered by their private insurance policy. If you buy a long term care insurance policy under the Partnership program and you use three years of nursing home care, or six years of home care, or some combination of the two, you may apply for NYS Medicaid benefits AND STILL RETAIN ALL YOUR ASSETS. You will, however, have to contribute your income to the cost of your long term care.

Insurance companies sell the Partnership policies, but they must carry the New York State Partnership for Long Term Care logo. The Partnership policy has two components:

- Private insurance which covers you for the three years of nursing home care or six years of home care which can be used wherever you choose; and
- Medicaid Extended Coverage which can only be used in NYS.

You can learn more information about long term care by visiting the Medicare web site at <http://www.medicare.gov/LongTermCare/Static/Home.asp> or by calling them at 1-800-633-4227. The New York State Partnership can be reached at 1-888-697-7582.

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Clip and Save These Resources

Attorney General's
 Health Care Hotline 1-800-771-7755
 EPIC 1-800-332-3742
 Healthy New York 1-866-432-5849
 LINCS 1-888-795-4627
 Medical Record
 (NYS Department of Health) ... 1-800-663-6114
 Medicaid's NYC Managed Care Consumer Assistance Program 1-212-614-5400
 Medicaid Helpline 1-888-692-6116
 Medicare 1-800-633-4227
 Medicare Rights Center 1-212-869-3850 and 1-800-333-4114
 New York City Government
 Info & Non-Emergency Services 311
 New York State
 Department of Health 1-800-663-6114
 New York State Health Insurance Assistance Hotline (SHIP) 1-800-701-0501
 New York State
 Insurance Department 1-212-480-6400
 New York State Partnership
 for Long Term Care 1-888-697-7582
 Social Security
 Administration 1-800-772-1213

PLEASE NOTE: All information offered in this newsletter is based on NYS law.