# EXAMPLES OF DIFFERENCES BETWEEN CURRENT MEDICFILL and DE's HIGHMARK MEDICARE ADVANTAGE PLAN

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## PRE-AUTHORIZATIONS

Medicare Part A and B pre-authorizations are "rare." (Medicare website)
The State's new Medicare Advantage Plan contains **2,030 pre-authorization requirements** -- 1,690 are for procedures and 340 for medications.

## "MEDICALLY NECESSARY"

Highmark will decide what services are "medically necessary" and will deny payment or authorization for any other service.
**Currently, our doctors make these decisions.**

If Highmark denies payment because it deems a service not "medically necessary" (after the fact), the retiree is responsible for full payment to the provider. **This is of particular concern to retirees treated out-of-network, where providers are not required to seek pre-authorization.**

## MEDICAL BENEFITS CHART

Highmark Medicare Advantage Plan (38 pages)

**Combined Out-of-Pocket Maximum --- $1,000.00.** (Pg.A1-3)
Some services do not apply to the Out-of-Pocket Maximum, so the retiree could actually pay more than $1,000.00.
**We currently pay $0**.

**"What you must pay when you get these services"**
The Medical Benefits Chart uses various terms throughout the 38 page booklet but does not define them and does not say how much they are. Terms used are co-payment, co-insurance, deductible, and cost-share.
**We currently pay none of these.**

**Emergency Ambulance Services** (pg. A1-5)
Highmark will cover emergency ambulance services only if other means of transportation could endanger the person's health. They will only take you to the nearest appropriate facility.

Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.
**In New Castle County, the paramedics and ambulance services operate separately, so Highmark could deny paramedic charges (if any) and the retiree would have to pay out-of-pocket.**

**Mammograms** (pg. A1-7)
Diagnostic testing is subject to diagnostic cost-sharing. (pg. A1-7)
**We currently pay $0.**

**Emergency care** (pg. A1-11)
Highmark covers emergency room care if you believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of a function of a limb. A co-payment applies unless you are admitted to the hospital.
**We currently do not pay for emergency room services.**

**Hearing services** (pg. A1-13)
Routine hearing services are not covered.
**We are covered under Medicfill and do not pay for routine hearing services.**

**Inpatient hospital care** (pg. A1-17)
Highmark pays while you are an inpatient. The day before you are discharged is your last inpatient day. Inpatient rehabilitation is not included.
**We are currently covered for all inpatient days and rehabilitation.**

**Inpatient stay: Covered services received in a hospital or skilled nursing facility during a non-covered inpatient stay** (pg. A1-19)
If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, Highmark will not cover your inpatient stay.
**Retirees have no way of knowing what Highmark will consider "reasonable and necessary" or when their benefits have been "exhausted." Retirees will be billed for those services and days.**

**Injectable Osteoporosis Drugs** (pg. A1-22)
Highmark will pay for injectable osteoporosis drugs under Part B "if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug."
**Our current plan pays under Part B for injections administered by a physician based on results of a bone density test.** It is unclear how the new plan would divide these costs with our Part D coverage --- and how a man or someone not homebound would qualify for the injections under Part B.

**Part B Drugs "Step Therapy"** (pg. A1-22)
"Step Therapy" (also known as "Fail First") is the process by which Highmark chooses which drugs we can receive under Part B, without regard to our doctor's recommendations. They will pay for the cheapest drug available and when that fails, they will move to the next cheapest drug, and so forth.
**Our current plan does not require that our drugs "fail first" before receiving the drugs that our doctors prescribe.**

**Outpatient diagnostic tests** (including laboratory tests) (pg.A1-23)
Outpatient diagnostic tests (including routine bloodwork) will require pre-authorization.
**Our current plan does not require pre-authorization for outpatient diagnostic tests ordered by our doctors. Outpatient diagnostic tests will be subject to "cost-sharing" under Highmark. We currently pay nothing.**

**Outpatient hospital observation** (pg. A1-24)
Unless you are admitted as an inpatient, you will be required to pay the "cost sharing" amounts for outpatient hospital services, even if you stay in the hospital overnight.
**Our current plan does not charge us for outpatient observation in a hospital.**

**Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** (pg.A1-26)
Unless you are admitted as an inpatient, you must pay the "cost-sharing" amounts for outpatient surgery.
**Our current plan does not charge us for outpatient surgery.**

**Basic hearing exams** (pg. A1-27)
Basic hearing exams by a specialist will be covered only if your doctor orders it to see if you need medical treatment.
**Our current plan does not require an order by our doctor and is fully covered.**

**Urgently needed services** (pg. A1-36)
Urgently needed services are covered only if it is not possible, or it is unreasonable, to obtain services from network providers (e.g. on a weekend). Cost sharing charges must be paid by retiree.
**Our current plan does not limit when a retiree can be treated at an urgent care facility and does not charge for the service. Also, Highmark can deny payment if they decide (after the fact) that the visit was not "medically necessary." In that case, the retiree would be responsible for the full cost of the visit.**

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The examples I have given of the differences between our current coverage under Medicfill and our future coverage under Medicare Advantage are limited to "in network" services only. Out of network coverage gets far more complicated.

The Medicare Advantage Medical Benefits Chart is extremely misleading and difficult to understand. For example, for some services, the Chart says that "*there is no coinsurance, copayment, or deductible*" for this service. For others, it simply says, *"$0 copay"* but nothing about deductibles, coinsurance, or cost sharing. The Chart sometimes refers to "coinsurance" and in other sections refers to "cost sharing." Are they the same thing? There are no definitions for any of these terms in the Chart.

The one section of the Chart that attempts to explain what retirees will be charged for services is completely useless. It says:
*"If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan."* (pg. A1-2)
Since we have no way of knowing what the coinsurance rate is or the reimbursement rate contained in the contract between Highmark and the provider, we have no idea how much we will be charged.
**What we do know is that our current Medicfill plan charges nothing!**