There has to be a better way
How to fix the healthcare system

By SCOTT HINES, MD

A lbert Einstein defines insanity as doing the same thing over and over again expecting different results. This perfectly describes the recent state of healthcare in our country. Almost daily we hear about the need to “bend the cost curve” to prevent medical expense from bankrupting our nation. While the country as a whole has been slow to adopt mechanisms by which to make care more affordable, New York State (NYS) has made significant strides over the past several years.

In 1960, 5% of Gross Domestic Product was spent on healthcare. By 2010 that number was up to 17.6%, with predictions that it will reach 20% by 2020. Even more alarming is the percentage of this expense that is coming out of the pockets of employers and employees in this country compared to other developed countries.

As more public money is spent on healthcare, less funding is available for other national priorities such as infrastructure, education and defense. Similarly, as more private money is spent on insurance premiums and out-of-pocket expenses, wages remain stagnant and workers have less discretionary income. So what can be done? The answer is transforming the healthcare system from one that incentivizes volume to one that incentivizes outcomes.

Today, much of the country is entrenched in fee-for-service medicine. This model rewards physicians and hospitals for the amount of care being provided regardless of whether or not that care is indicated or helpful. Providing coordinated care to medically complex patients is labor intensive and difficult to sustain in a payment model that rewards volume. This leads to an increased number of specialist referrals and fragmented care.

The Affordable Care Act (ACA) addressed this driver of cost by putting into legislative language the concept of Accountable Care Organizations (ACOs) through the establishment of the Medicare Shared Savings Program (MSSP). An ACO is defined as a group of healthcare physicians with a strong primary-care base, who are jointly responsible for quality and per capita cost across the continuum of care for a defined patient population. The Centers for Medicare and Medicaid Services (CMS) has capitalized on this concept by allowing ACOs to participate in this new payment model in an effort to help the agency reach its goal of having 30% of Medicare beneficiaries participating in alternative payment models by 2016 and 50% by 2018.

Given the promise of ACOs, one would think that the medical community would have embraced the concepts of value and accelerated its adoption. Unfortunately that has not been the case.

Challenges

While many physicians agree that payment models that reward outcomes over volume are the best hope for containing healthcare costs, there are many challenges that prevent practices from jumping head first into such a transformation. The first is the need for investments in infrastructure, technology and personnel that will allow organizations to succeed in an era where they are responsible for both quality and cost. Electronic medical records (EMRs) are essential to insure care coordination. Software that identifies patients at greatest risk for medical complications, ER visits and inpatient admissions is necessary if practices hope to intervene before these costly services are needed. Care managers, social workers and clinical pharmacologists must be hired to augment the care team and provide patient education regarding care plans, psychosocial determinants of health and complex medication regimens, respectively. These are costly competencies that traditional medical practices do not possess and take many years to develop prior to seeing a return on investment.

A second challenge for developing ACOs is the need for both providers and their payer partners—the companies responsible for making healthcare payments—to become interested in alternative payment models. Given the dichotomy between a fee-for-service payment model that incentivizes volume and a value-based payment model that incentivizes outcomes, physicians often find themselves with competing priorities and the feeling as if they have “a foot in both canoes.” That means payers need to be willing to craft a payment model that rewards practices for the investments made in this new care model and the savings that they create, to incentivize physicians to move to the ACO “canoe.” Furthermore, there needs to be standardization among plans so that the rules of engagement are similar in order to reduce the complexity of this transition.

A third challenge is the lack of transparent quality and cost data for both patients and physicians. Succeeding in a value-based payment model means delivering the highest quality of care at a reasonable price. If patients are not provided with clear, easy-to-understand data, how can they decide where to seek their care? Imagine you were asked to buy a car but were not told how many miles the gallon the car could achieve, its safety profile, or its costs. That sounds insane, but it is exactly what patients are expected to do with their healthcare. It is very challenging for patients and referring physicians to find data related to physician performance around standardized quality metrics such as cancer screening and diabetes outcomes. Determining how much a visit, diagnostic test or procedure costs at different practices or hospitals is nearly impossible. This prevents both patients and physicians from making educated choices on where to obtain care.

Solutions

While these challenges may seem daunting they have solutions, and NYS is positioning itself as a national leader in this space. One way to incentivize medical practices to invest in the infrastructure, technology and personnel necessary to succeed as an ACO is to make capital more readily available. This could take the form of tax-free investments or grants from the state to promote such a transformation. NYS has multiple programs to help practices invest in their future such as the Delivery System Reform Incentive Payment (DSRIP), the Advanced Primary Care (APC) model, the Transforming Clinical Practice Initiative (TCPI) program and state incentives for Patient-Centered Medical Homes.

Having payer partners that offer monthly payments to medical groups to invest in transformation is essential. Likewise, having multiple payers in a given geography offer alternative payment models with similar quality measures and rules of engagement will help reduce the complexities of the system that medical practices are attempting to navigate. Commercial payers in NYS involved in the APC model are attempting to standardize quality measures and attribution methodology. In addition, the state’s Value-based Payment Roadmap has mandated that 80 to 90% of patients enrolled in Managed Medicaid be involved in value-based payments by 2019.

Access to transparent quality and cost data remains a challenge. NYS should incentivize physicians and hospi-

Continued on page 2
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Better Way
Continued from page 1

tals to publicize their clinical quality results. Likewise, the state should require insurers to publicize cost data related to office visits, diagnostic testing and procedures at various institutions in their region. Doing so will allow physicians and patients to work together to identify the highest-quality and lowest-cost choice available.

The areas of the country that provide the least expensive care were early adopters of value-based care. By incentivizing physicians, payers, and patients to move away from fee-for-service and toward a system that rewards value, NYS will soon join these early adopters and provide a model of care that can be emulated across the country.

[Scott Hines, MD, is Chief Quality Officer at Crystal Run Health Care, the first facility in New York State and one of the first six in the country to receive accreditation as an Accountable Care Organization.]

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Food fight!

By BARBARA GRIGGS-PRATT

Inflammation is caused when our immune system attacks an intruder, like pollen, germs, or a splinter. And that’s a good thing. But when inflammation persists, day in and day out, even when you are not threatened by a foreign invader, inflammation can wreak havoc. Many major diseases, including cancer, diabetes, arthritis, heart disease and even depression and Alzheimer’s disease are linked to inflammation and the inflammatory response.

What to eat (or not)

While certain medications have anti-inflammatory effects, the best way to quell inflammation is to make dietary changes. Not surprisingly, the same foods that are considered to be bad for our health are the culprits in the inflammatory process. These same unhealthy foods contribute to weight gain, which is, in itself, a risk factor for inflammation. They include refined carbohydrates such as white bread and pastries, French fries and other fried foods, soda and sugar-sweetened beverages, red and processed meats and margarine, shortening and lard. Avoid trans fat at all costs—most food companies have now removed them from crackers, chips and other such products, but check labels to make sure.

On the flip side, eating a healthy diet can reduce inflammation and the risk of chronic disease as well as help avoid obesity. In addition to lowering inflammation, a diet high in whole foods—foods that haven’t been processed—can have noticeable effects on physical and emotional health, with the potential to improve mood and quality of life.

What are the top foods we should be eating to gain these benefits? Plenty of fruits and vegetables (five servings a day can help significantly reduce your cancer risk); include blueberries (tops in antioxidants) and other colorful foods like tomatoes, cherries, green leafy vegetables, apples and butternut squash. Nuts of all kinds reduce cardiovascular disease risk and are rich in “good” fats, as are olive oil, avocado and fatty fish like salmon and sardines. Sesame oil and seeds, soybeans and omega-3s in herring, mackerel, tuna and trout are also recommended.

Coffee is high in polyphenols and intake is associated with a lower risk of Type II diabetes. Parkinson’s disease and liver cancer: Green tea is also a great choice. Also, drink lots of pure water.

How to cook

Changing your cooking methods will also help reduce inflammation. You can lose much of the benefit provided by healthy foods by cooking them the wrong way.

When roasting, place the food in the middle of the glass or ceramic baking dish to allow room for air to circulate around the sides. Putting the vegetables on the bottom, under the meat or fish, adds moisture and improves flavor. Cover the dish to allow steaming of the food. Use a vegetable steamer, rice cooker, or bamboo steamer to gently cook a variety of foods while retaining their nutritional value. Marinate foods with rosemary and sage before steaming and add ginger or turmeric for an extra anti-inflammatory infusion.

Stir-frying requires little oil, and vegetables retain their important nutritional value with this method. Grilling is great for fish and veggies, but remember to pre-cook and marinate meats before grilling to reduce the production of carcinogenic heterocyclic amines.

[Changing your diet can be challenging, but the week’s worth of meal ideas Griggs-Pratt has put together (see next page) should help get you started.]

12 anti-inflammatory foods to incorporate into your daily diet:
Avocados, blueberries, broccoli, celery, cranberries, ginger, hemp seeds, papaya, red cabbage, turmeric, walnuts and salmon

[Barbara Griggs-Pratt is Clinical Nutrition Manager at Wayne Memorial Hospital.]
Seven days of healthy eating
Fight inflammation, disease and obesity before they get started

By BARBARA GRIGGS-PRATT

Breakfast
Mon.: Steel-cut oatmeal, berries, yogurt and coffee
Tues.: Oatmeal with chopped almonds, wheat toast and grapefruit
Wed.: Omega-3 enriched eggs over wilted greens, toasted quinoa
Thurs.: Yogurt parfait (yogurt, granola, flax seed, berries)
Fri.: Smoothie (banana, blueberries, peanut butter, almond milk, ice)
Sat.: Veggie omelet w/ spinach and tomato
Sun.: Low-fat cottage cheese w/ pineapple and melon w/ whole wheat toast

Lunch
Mon.: Tuna salad on seven-grain bread, smoothie, seasonal fruits
Tues.: Herb and honey-walnut crusted salmon, brown rice, sweet potatoes, pure water (see recipe)
Wed.: Greens, chickpeas, mandarin oranges, Triscuit crackers and green tea
Thurs.: Mixed greens, cranberries, walnuts, bell pepper, feta cheese w/ raspberry vinaigrette
Fri.: Pita bread w/ grilled chicken, roasted red peppers and carrot sticks
Sat.: Tuna on a whole-wheat wrap w/ spinach, onion, tomato and cucumber salad
Sun.: Turkey and avocado on whole wheat bread w/ lettuce and tomato, side of chickpea salad

Dinner
Mon.: Spaghetti, turkey-meat sauce, spinach salad with walnuts and cranberries
Tues.: Alaskan salmon, celery and red cabbage salad, brown rice, pure water
Wed.: Chicken curry, whole grain bread, yogurt and papaya
Thurs.: Cauliflower pizza w/ sun-dried tomatoes and olives
Fri.: Vegetable stir fry w/ brown rice, snow peas, onions, garlic, peppers, carrots
Sat.: Shrimp kabobs w/ broccoli, onion, bell pepper, baked potato
Sun.: Vegetable-stuffed cabbage w/ rice, mushrooms, onions and garlic

Herb and honey walnut-crusted salmon

Ingredients
1 1/2 lbs salmon fillets (4 oz each)
Freshly ground sea salt and pepper to taste
2 Tbsp. stone-ground mustard
2 Tbsp. honey
2 tsp. finely chopped fresh basil or tarragon
2 garlic cloves, minced
½ cup finely chopped walnuts
6 cups baby arugula or spring mixed greens
2 Tbsp. extra virgin olive oil
2 Tbsp. balsamic vinegar

Directions:
Preheat oven to 400°F. Place salmon on a baking sheet sprayed with non stick cooking spray and season with salt and pepper. Stir the mustard, honey, herbs and garlic, then spread over the salmon. Sprinkle with walnuts and bake for 10-15 minutes, or until salmon flakes easily with a fork. Toss the greens with oil and vinegar. Arrange the greens on 6 plates and top each serving with a salmon fillet.
Makes six servings
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September is National Recovery Month - This message is sponsored by Assemblywoman Aileen Gunther

In Sullivan County

Sullivan County Public Health Services
Addiction Referral Line: 866-832-6575
If you or someone you know has a drug or alcohol problem, or mental health concerns, call 866-832-5575. Information and referrals for treatment and recovery services are confidential and are provided free of charge.
50 Community Lane, Liberty, NY
Nancy McGraw, LCSW, MBA, Director
www.co.sullivan.ny.us

Sullivan County Department of Community Services
845-926-8770
Providing services in mental health, alcoholism and drug abuse, including an outpatient program and clinic. Evaluations for appropriateness.
20 Community Lane, Liberty, NY
Melissa A. Stickle, Program Director
www.co.sullivan.ny.us

Catskill Regional Medical Center
845-794-2300
Important opioid treatment for adolescents and adults. Those seeking treatment should present themselves in the emergency room for assessment of signs and symptoms of withdrawal. If detox is needed, patient will be admitted.
68 Harris Bushvile Road, Harris, NY
www.crmcm.org

Catholic Charities of Orange/Sullivan
845-794-8880
A 24-hour crisis center, serving local residents suffering from drug and alcohol abuse. Services include self-search, outpatient, community, residential, medically supervised withdrawal (inpatient included), and supportive living. Family members are eligible for and encouraged to participate in therapy.
209 Broadway, Monticello, NY
Martin Coletivo, Prevention Director
www.catholiccharitiesny.org

Friends of Recovery - Sullivan County
845-865-1226
Friends of Recovery – Sullivan County is a grassroots Recovery Community Organization (RCO) for people and families seeking help with recovery and resources. They offer: group, individual, and family therapy; sober, treatment recovery coaches and coaching coach training.
Pamela Pozoera-Krus, President
PamAnne42@gmail.com

New Hope Manor
845-657-5933
All-female, residential substance abuse treatment with variable lengths of stay for women ages 13 and up, including those who are pregnant, those who would like to have young children under 5 stay with them while they are in treatment, and any woman in need of services.
Barrie Jacobsen, LCSW-R, Executive Director
www.newhopemanor.org

National Alliance on Mental Illness (NAMI)
845-734-3092
A 12-step program that provides free support to alcoholics. Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. There are no dues or fees for AA membership.
For Sullivan County: www.bird-aa.com
For Orange County: www.oiran.org

The Kingfisher Project
Email: kingfisher1fg@gmail.com
A community radio project based at W.U.F. Jeffersonville, NY, 90.5 FM. The Kingfisher Project produces community radio shows that tell the stories of those affected by addiction, honor the lives of everyone affected by substance abuse and remembers the talents, dreams and good hearts of those who have died.
www.thekingfisherproject.com

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845-794-9100
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Alcoholics Anonymous
845-734-3092
A 12-step program that provides free support to alcoholics. Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. There are no dues or fees for AA membership.

For Sullivan County: www.bird-aa.com
For Orange County: www.oiran.org

Al-Anon/Alateen
24-hour Answering Service: 845-339-5426
Founded over 50 years ago by families of alcoholics who had first recovered in Alcoholics Anonymous. Al-Anon/Alateen provides free support meetings for families and friends of alcoholics who live with alcohol and drug abuse.
When calling this number you will receive a name and confidential phone number to call to find a meeting.
www.al-anon-ulster-sullivan.ny.org

Narcotics Anonymous
888-393-5559
A non-profit organization and society of men and women for whom drugs have become a major problem.
www.na.org/meetings

In Orange County

Family Support Navigation Program
845-294-5000
Supporting families struggling with a substance abuse disorder. A holistic, integrative, and kind approach to finding help. Helping navigate resources and information on treatment, social services recovery and self-help groups. All services are confidential and free of charge.
224 Main Street, Goshen, NY
www.adasinfo.com

HONOR Helping Others Needing Resources - Middletown Addiction Crisis Center
845-343-7122
Adult and family shelters providing emergency housing for emergency situations in the families. Gabies are provided three meals each day, transportation, and counseling to help them to become self-sufficient.
38 Second Avenue, Middletown, NY
www.honoringhelpethers.org

Orange Regional Medical Center
845-315-7860
Orange Regional Medical Center’s Substance Abuse Treatment Program offers substance abuse assessment and treatment recommendations, individual counseling, group therapy, intensive outpatient services, case management, and individualized treatment development and planning.
www.ormc.org/services/behavioral-mental-health

RECAP - New Life Manor
Admissions: 845-666-5224
An OASAS licensed treatment facility specializing in chemical dependency treatment. New Life Manor’s staff helps men in recovery from drug and alcohol addiction on their path to recovery.
40 Smith Street, Middletown, NY
www.recap.org/programs/newlifemanor

Richard C. Ward Addiction Treatment Center
Admissions: 845-343-2111
The Richard C. Ward Addiction Treatment Center is a 60-bed inpatient facility offering innovative treatment and services to aid in the recovery of addicts and their families.
117 Seward Ave, Middletown, NY 10940
Mary Johnson LMSW Director
www.orsas.org/adirward

An Emergency:
Call 911 or go to the Emergency Room

Call the Mobile Mental Health Unit: 800-710-7082

For County Resources: Call the 24-hour referral line: 866-832-5575

A message from Aileen

Dear Friends,

We’ve seen the statistics—nearly half of all Americans know someone personally who is addicted to prescription painkillers; one in ten New Yorkers suffers from a substance abuse disorder. That’s one in every ten of our family members, friends, and neighbors. Sullivan County isn’t immune. Drug abuse is having a detrimental effect on our communities and the people who live here.

It’s important to know that help is out there. Every day in our community, many of whom have faced the same issues and themselves, are helping people overcome their addiction. We’re lucky to have such tremendous resources for those suffering. However, it’s important to get the word out to people that these services are available. Middletown:

- Monticello (845-794-5807)
- Middletown (845-342-9304)
- Albany (518-455-5355)

Sincerely,

Aileen Gunther
Member of Assembly

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Agencies and groups offering addiction and recovery support

In Orange County

Richard C. Ward Addiction Treatment Center
Admissions: 845-343-2111
The Richard C. Ward Addiction Treatment Center is a 60-bed inpatient facility offering innovative treatment and services to aid in the recovery of addicts and their families.
117 Seward Ave, Middletown, NY 10940
Mary Johnson LMSW Director
www.orsas.org/adirward

In Sullivan County

Monticello (845-794-5807)
Middletown (845-342-9304)
Albany (518-455-5355)

An Educational Program by Aileen Gunther

In an Emergency:
Call 911 or go to the Emergency Room

Call the Mobile Mental Health Unit: 800-710-7082

For County Resources: Call the 24-hour referral line: 866-832-5575
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Medicare 101

Help for beginners making their way through the thicket of parts and plans

By ERINN BRAUN

WHAT IS MEDICARE?

Medicare is health insurance offered by the Federal government available to people aged 65 and over, or to people with certain disabilities.

THE PARTS OF MEDICARE

Part A (hospital insurance) covers most medically necessary in-patient hospital care, skilled nursing facility care, home health care and hospice care. It is free if you have worked and paid Social Security taxes for at least 40 calendar quarters (10 years); you will pay a monthly premium if you have worked and paid taxes for less time. There is a deductible per benefit period, paid upon admission to the hospital (The 2017 deductible is $1,316).

Part B (medical insurance) covers 80% of most medically necessary doctor services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, X-rays, mental health care and some home health and ambulance services. You are responsible for 20% co-insurance after you meet the annual deductible (the 2017 deductible is $183). You pay a monthly premium for Part B which varies based on your income and when your coverage became effective (the 2017 standard monthly premium is $134).

Medicare Part D is the part of Medicare that provides outpatient prescription drug coverage. Part D is provided only through private insurance companies that have contracts with the government—it is never provided directly by the government (as original Medicare is). There is a monthly premium for Part D, depending on the coverage that you choose (2017 Part D premiums range in cost from $14.60 to $106.40). Deductibles and co-pays at the pharmacy may apply.

Parts A, B and D are required for most people at the age of 65, or have Medicare due to disability. If you or your spouse have health coverage through active/current employment you may be able to delay enrollment.

MEDICARE TERMS

Co-insurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Deductible – The amount you must pay for health care or prescriptions before original Medicare, your prescription drug plan, or your other insurance begins to pay.

Co-payment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or prescription drug.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

MEDICARE ADVANTAGE VS. MEDIGAP

Medicare Part C is not a separate benefit. Part C is the part of Medicare policy that allows private health insurance companies to provide Medicare benefits. These Medicare private health plans, such as HMOs and PPOs, are known as Medicare Advantage Plans. You can choose to get your Medicare coverage through a Medicare Advantage Plan instead of through original Medicare. However, you must be enrolled in Medicare Part A and Part B to enroll in a Medicare Advantage Plan. Also, it’s important to note that in original Medicare, you are covered to go to nearly all doctors and hospitals in the country. Medicare Advantage plans are usually regional and have network restrictions, so it’s extremely important to check whether their plans include your preferred local providers.

Medicare Advantage Plans offer equivalent benefits as original Medicare (those covered under Parts A and B) but can do so with different rules, costs and coverage restrictions, generally resulting in lower co-pays and deductibles. You also typically get Part D, prescription drug coverage, as part of your Medicare Advantage benefits package. There are different kinds of Medicare Advantage Plans available. Some provide additional benefits that original Medicare does not cover, such as routine vision and routine dental care. You may pay a monthly premium for this coverage, in addition to your Part B premium—though some policies have $0 premiums—and co-pays may apply.

Medicare Supplement Insurance (Medigap) policies are sold by private companies and can help pay some of the health care costs that original Medicare does not cover, like copayments, coinsurance and deductibles. Some Medigap policies also offer coverage for services that original Medicare doesn’t cover, like medical care when you travel outside the U.S. If you have original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share. Medigap policies do not, however, cover prescription drugs.

While Medicare Advantage Plans are a way to get your Medicare benefits through a private insurer, a Medigap policy merely supplements your original Medicare benefits. And unlike Medicare Advantage plans, Medigap policies can be used anywhere that accepts original Medicare, anywhere in the country. Medigap policies have a monthly premium that you will pay in addition to your Medicare Part B premium and Part D premium.

PAYING FOR MEDICARE

For most beneficiaries collecting Social Security, the amount that you owe for your Part B premium will be deducted from your Social Security check every month. Beneficiaries who enroll in Medicare but choose to not yet collect Social Security will be billed quarterly, in advance, for the Part B premium.

HELP WITH MEDICARE COSTS

The Medicare Savings Program (MSP) is an income-based program that will pay the Part B premium for those who qualify. This program is income based and eligibility is determined by your local department of Social Services. In 2017, income below $1,377 (individual) / $1,847 (couple) may qualify you for the Medicare Savings Program. If a beneficiary qualifies for MSP, he/she will automatically qualify for the Extra-Help program. A beneficiary can contact their local Department of Social Services or SHIP counseling office (see “Helpful Resources” box on next page) for an application.

Extra-Help is a program run by the Social Security Administration. The purpose of this program is to keep the costs of prescription drugs down. There are different levels of the Extra-Help program based on income and assets (full extra-help/partial extra-help). Depending on

When to sign up: avoid penalties

You sign up for Medicare with the Social Security Administration, but do not have to sign up for retirement benefits at the same time. You should enroll during your Initial Enrollment Period (IEP), a seven-month period that begins three months before turning age 65, the birthday month, and the three months after reaching 65.

If you delay enrollment into Medicare Part B, and do not have coverage through your or your spouse’s active/current employment, you may face a penalty of 10% on your Medicare Part B premiums for every 12 months that you were eligible for Part B but didn’t sign up for it. You also may not have another opportunity to enroll until the General Enrollment Period, an annual period running January through March, and coverage does not begin until July of that year.

To avoid penalties for Part D (prescription coverage), make sure that you do not go through a consecutive period of more than 63 days, after the date when you first become eligible to receive Medicare, when you are not covered either by Part D (including an Advantage Plan), or by “creditable coverage” (the insurer should notify you annually if its coverage qualifies as “creditable”).

If you let such a period lapse and then enroll later, you may be liable for a Late Enrollment Penalty (LEP). The LEP is based on a percentage of the national premium multiplied by the number of months a person has been without Part D.

What are my Medicare coverage choices?

There are two main ways to get your Medicare coverage – Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide which way to get your coverage.

START

STEP 1: Decide how you want to get your coverage

ORIGINAL MEDICARE

OR

MEDICARE ADVANTAGE PLAN

Part C (like an HMO or PPO)

STEP 2: Decide if you need to add drug coverage

Part D

Prescription Drug Coverage

(Most Medicare Advantage Plans cover prescription drugs. You may be able to add drug coverage in some plan types if not already included.)

STEP 3: Decide if you need to add supplemental coverage

Medicare Supplement Insurance

(Medigap policy)

END

If you join a Medicare Advantage Plan, you can’t use or be sold a Medicare Supplement Insurance (Medigap) policy.
what level of Extra-Help you qualify for. In 2017 your prescription costs will be $3.30/$8.25. A beneficiary can apply for Extra-Help on-line at https://secure.ssa.gov/I1020/start, or contact your local Social Security office for an application.

Elderly Pharmaceutical Insurance Coverage Program (EPIC) is New York State’s pharmaceutical assistance program administered by NYS Department of Health (visit https://www.health.ny.gov/health_care/epic/or call 800/332-3742).


[Erinn Braun is a Special Programs Assistant at HIICAP for the Orange County Office of the Aging.]

HELPFUL RESOURCES

Medicare.gov — For those who feel comfortable using on-line resources, medicare.gov offers a lot of valuable information, including a Medicare Plan Finder tool which allows beneficiaries to enter their prescription drugs and generate a comparison of plans available within their region.

Medicare Interactive — Medicare Interactive provides easy-to-understand answers to the questions posed by Americans with Medicare, their families and caregivers, and the professionals serving them. Visit www.medicareinteractive.

SHIP Counselor — All states have State Health Insurance Program (SHIP) counselors. They provide free, accurate and objective information, counseling, assistance and advocacy on Medicare, private health insurance and related health coverage plans to people with Medicare, their representatives, or persons soon to be eligible.

New York State’s SHIP is known as Health Insurance Information Counseling and Assistance Program (HIICAP). In Sullivan County, call 845/807-0241. For Orange County, call 845/615-3715. For other counties, call 800/701-0501 and give your county name.

Pennsylvania’s SHIP is called the APPRISE Health Insurance Counseling Program, and information can be found on its website, www.aging.pa.gov/aging-services/insurance/Pages/default.aspx, or call 800/783-7067.

Senior Medicare Patrol (SMP) — The Senior Medicare Patrol (SMP) is part of a nationwide education and assistance program working to empower seniors and caregivers to prevent, detect, and report Medicare fraud and waste. You can report suspected problems to SMP. In New York, you can contact the SMP hotline at 877/678-4697. For PA, call 800/356-3606.

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