Medicare Advantage (Part C): An Overview

Medicare Advantage is also known as Medicare Part C. A Medicare Advantage (MA) plan is an alternative to Original fee-for-service Medicare. Medicare sponsors MA plans as part of the Medicare program and pays private insurance companies to provide health services to beneficiaries who have enrolled in these plans.

In order to join an MA plan, you must be enrolled in both Medicare Part A and Part B and must continue to pay the Part B premium ($96.40 in 2009). If you join a Medicare Advantage plan, you are still on Medicare and still retain the full rights and protections entitled to all Medicare beneficiaries.

You receive all Medicare-covered benefits through the private plan you choose. Some Medicare Advantage plans offer Medicare prescription drug coverage (known as "MA-PD" plans), but other plans do not (known as "MA-only" plans). Most Medicare Advantage plans have extra benefits and may charge lower co-payments than Original Medicare. Yet, several MA plans do charge the same or more than Original Medicare for certain services. Many Medicare Advantage plans require you to see doctors who belong to the plan's network and/or go to certain hospitals to get services.

There are 5 types of Medicare Advantage plans:

1. Medicare Health Maintenance Organizations (HMOs)
2. Medicare Preferred Provider Organizations (PPOs)
3. Medicare Private Fee-for-Service Plans (PFFS)
4. Medicare Special Needs Plans (SNPs)
5. Medicare Medical Savings Accounts (MSAs)

Medicare HMOs

If you enroll in a Medicare HMO (*Health Maintenance Organization*), you are required to use only doctors and facilities that contract with that particular HMO. You choose a primary care doctor who manages your health care needs. Before you see a specialist in your HMO network (except for an OB-GYN), you must generally get a referral from your primary care doctor. This requirement is waived in such cases as emergency care, out-of-the area urgent care, or with a pre-approved referral to a doctor outside the HMO network.

If you want to see a doctor outside the plan, and you do not have a pre-approved referral, you cannot use your Medicare Advantage plan card or your Medicare card to pay for those services. You have to pay for the costs of your care.

Some HMOs offer a Point-of-Service (POS) option, which allows an enrollee to see doctors outside the HMO's network. Usually, however, HMOs charge for this option and may limit when you can use it.

Some HMOs offer Medicare prescription drug coverage and others do not. If you are in an HMO plan that does not offer prescription drug coverage, you generally cannot get other prescription drug coverage outside your plan.

HMOs are the most popular type of Medicare Advantage plan in California, but they are not available in every part of the state. California's *HMO Guide for Seniors*, produced by the University of California, Berkeley and the state's Office of the Patient Advocate is a resource to learn about how managed care plans work, and help you understand your rights so you can get the most out of your plan. You can obtain a free copy at http://tinyurl.com/6fze6o

Medicare PPOs

Medicare PPOs (*Preferred Provider Organizations*), like Medicare HMOs, have networks of providers. If you see providers in the network, you pay a lower co-payment than if you go to providers outside the network ("out-of-

network" or "non-preferred"). Thus, if you go to "out-of-network" providers, the plan still covers you but at a lower rate, i.e. your co-payment is higher. In a PPO, you do not generally need a referral to see a specialist or any out-of-network provider.

In 2009, one regional PPO is available statewide in California and it offers Medicare prescription drug coverage. The PPO plan has a deductible that must be met before plan benefits start, but the deductible does not apply to certain benefits, such as doctor visits and preventive services. There is also an annual limit on out-of-pocket costs. After the enrollee has spent the out-of-pocket maximum, the plan pays 100% of all covered-services for the remainder of that year.

Medicare PFFS Plans

Medicare PFFS (*Private Fee-for-Service*) plans are offered by private companies and allow you to go to any doctor or hospital *as long as they accept the terms of your plan's payment*. Before enrolling in a Medicare PFFS plan, make sure that your doctors and other health care providers accept the plan's terms and conditions for payment. Even if you did not check whether your doctors accept the plan's payment but have enrolled in a Medicare PFFS plan, present your plan card to the provider's office before you receive a service. Your providers must agree to bill the plan, not Medicare, for their services. Providers cannot provide you service if they do not agree to the plan's payment terms and conditions. The private company (not Medicare) decides how much it pays providers and your cost-sharing is for the services you receive.

There are multiple Medicare PFFS plans in every county. Some plans offer Medicare prescription drug coverage. If a Medicare PFFS plan does not offer prescription drug coverage, you can join a separate Medicare prescription drug plan. In addition, a PFFS plan *may* offer extra benefits not covered under Original Medicare, such as extra days in the hospital.

Medicare SNPs

Medicare SNPs (*Special Needs Plans*) are designed for certain populations. There are 3 types of SNPs: for people in certain institutions (like a nursing home) or who still live at home but need the same care as someone living in a nursing home; for people who are eligible for both Medicare and free Medi-Cal ("dual eligibles"); and for people with certain chronic or disabling conditions.

The goal of these plans is to provide coordinated health care and services to those who can benefit the most from the special expertise of the plans' providers and focused care management. All SNPs must provide Medicare prescription drug coverage. Most of these plans offer extra benefits and lower co-payments than in Original Medicare. These plans are available in some, but not all, areas of California.

Medicare MSAs

Medicare MSAs (*Medical Savings Accounts*) were available for the first time in California in 2007 and are offered again in 2009. MSAs have 2 parts: 1) a high deductible health plan that covers Medicare Parts A and B services once the high deductible is met; and 2) a medical savings account – an independent bank account into which Medicare makes a deposit, which can be used to pay for health care services (including meeting the health plan deductible). Note that the amount Medicare deposits is less than the deductible. Thus an individual must pay the deductible before the plan covers Medicare Parts A and B services.

MSAs cannot offer Medicare prescription drug coverage, so MSA enrollees can enroll in a separate stand-alone Medicare Part D plan. MSAs are available throughout California except for 6 counties (Glenn, Inyo, Lassen, Los Angeles, Marin, and Orange County).

Costs and Benefits

Medicare Advantage plans contract with Medicare on an annual basis. Medicare pays a plan a fixed monthly amount for each Medicare beneficiary who enrolls. This amount is readjusted each year based on a formula created by Medicare and it varies from county to county. In turn, the plan must provide, at a minimum, all Medicare-covered services. It may also choose to provide additional services not covered by Medicare, such as hearing, dental,

and eye exams. These additional services can vary by specific geographic areas.

Based on the monthly amount it receives from Medicare, the plan takes the financial risk of providing all medically necessary services regardless of how many people use their services, how often services are provided, or how costly the services are.

Premiums vary from region to region, and the range in 2009 is from $0 to $201 a month. You continue to pay the Part B monthly premium. Additionally, most MA plans require a co-payment for services, such as doctor visits.

As mentioned above, many MA plans offer Medicare prescription drug coverage. If you enroll in such a plan, you do not need to enroll in a stand-alone Medicare Part D plan.

Enrollment

You may enroll in an MA plan so long as you have Medicare Parts A and B. *MA plans do not require health screening, and you cannot be denied enrollment in an MA plan due to a pre-existing condition, with the exception of having end stage renal disease (ESRD).* If you have been diagnosed with ESRD, also known as kidney failure, you are not eligible to enroll in an MA plan (in most cases). But if you develop ESRD while already enrolled in a MA plan, the plan cannot disenroll you. See our fact sheet "Medicare and People with End Stage Renal Disease" at cahealthadvocates.org.

If you want to join an MA plan, you must reside in the plan's service area and enroll during an applicable enrollment period. Since 2006, Medicare beneficiaries are allowed to enroll into MA plans only during the following periods:

1. Initial Coverage Election Period (for people newly eligible for Medicare)
2. Annual Election Period (from November 15th through December 31st each year)
3. Open Enrollment Period (from January 1st through March 31st each year)
4. Special Enrollment Periods (depending on the situation, such as moving out of the plan's service area)

To enroll, submit your application directly to the plan or a plan sales representative or call 1-800-MEDICARE. The effective date of coverage depends on the period in which you enroll. Remember not to drop your existing coverage, if any, until your coverage with your preferred MA plan is in effect. **Note:** You may enroll in a Medicare MSA only during your Initial Coverage Election Period and Annual Election Period.

Disenrollment

If you decide to change from one Medicare Advantage plan to another, successful enrolling in a new plan automatically disenrolls you from the current plan. Remember that, in general, you can only make these changes during the Annual Election Period, the Open Enrollment Period, or if you have a Special Enrollment Period.

Similarly, if you want to switch from an MA-PD plan to a stand-alone Medicare Part D plan, by successfully enrolling in the Part D plan, you are automatically disenrolled from the MA-PD plan. You do not have to affirmatively disenroll from the MA plan. Another example: if you are in a Medicare Part D plan and wish to switch to an MA-PD plan, enrolling in the MA-PD plan automatically disenrolls you from the Medicare Part D plan. **Note:** You may disenroll from a Medicare MSA only during the Annual Election Period and a Special Enrollment Period, if you have one.

If you want to get out of an MA plan, and you don't want to join another MA or Medicare Part D plan, you must send a written request to the plan or call 1-800-MEDICARE during the enrollment periods mentioned above. The effective date of your disenrollment depends on when the request for disenrollment is made. For example, if you disenroll during the Annual Election Period, the change will be effective the following January 1.

If you are disenrolling from a Medicare HMO plan or Medicare SNP, you must continue to use providers and services in the plan's network until the date your disenrollment becomes effective. Otherwise, the plan will not pay, and Medicare will not pay, because Medicare HMOs and SNPs require enrollees to use providers in the plan's network.

Medicare PPOs and PFFS plans do not limit enrollees to a network. If you are disenrolling from a Medicare PPO plan, and you use providers outside of the PPO plan's network before the effective disenrollment date, the PPO plan covers it at the lower out-of-network rate. If you are disenrolling from a Medicare PFFS plan, before the effective disenrollment date, you must see providers who accept the plan's payment terms and conditions.

For more information, see our fact sheet on Medicare Enrollment Periods and series of fact sheets on Prescription Drugs at cahealthadvocates.org.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.