

MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Objectives

Below are the topics covered in Module 5, Medicare Advantage (MA) Health Plan Options. This module will help to ensure that HIICAP counselors understand all the options available to people with Medicare and give counselors the tools to assist their clients in making wise independent choices.

At the end of this module are the Study Guide Test and Answer Key.

What Medicare options do I have in New York State?

- Original Medicare
- Original Medicare with a Supplemental Insurance Policy (Medigap)
- Medicare Advantage Plans (MAPs)
- Special Needs Plans (SNPs)
- Certain individuals who are enrolled in both Medicare and Medicaid **and** who need Long Term Care Services may have other choices such as a Fully Integrated Duals Advantage (FIDA) program. These options will be discussed briefly later in this module. Please refer to Module 17 (*Medicaid*) of the HIICAP Notebook for a full description.
 - <https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod17.pdf>

What is required to be eligible for a Medicare Advantage health plan?

- Must have Medicare Part A **and** Medicare Part B
- Must live within the plan's service area where plan accepts enrollees
- Cannot have End-stage Renal Disease at time of enrollment (with certain exceptions)

How does someone choose an option?

- Comparing different Medicare Advantage plans in their area. When choosing an option, one must also compare having an MA plan vs. the flexibility of remaining with Original Medicare with or without a supplemental plan and/or employer (or retiree) insurance.
- Choosing a primary care physician (specific to HMO plans).

Medicare Advantage (MA) Star Ratings

- The star ratings system began in 2007 as a way for CMS and Medicare beneficiaries to assess MA health plans.
- Medicare gives star ratings for health plan quality and performance. The top rating is five stars. Plans with the ratings of four or five stars get extra money from the government to spend on medical benefits.
- The measures target a broad array of beneficiary experience areas including customer satisfaction and the quality of care the plan delivers.
 - <https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx>

Why join a Medicare Advantage (MA) plan?

- Predictable copayments for doctor visits and other medical services (outpatient)
- MA plans may offer benefits not available in Original Medicare, such as dental care, hearing aids, or eyeglasses.
- Maximum Out-of-Pocket amounts (MOOP).
 - All MA plans must have a yearly MOOP amounts for all Part A and B covered services, not to exceed \$6,700 (HMO) and \$10,000 (PPO), including \$6,700 in-network. This is a key benefit and protection for the beneficiary. MOOP will be discussed in further detail later in this module.

What should be considered before joining a MA plan?

- What is the plan premium and what are other out-of-pocket costs?
- What providers are available to members?
 - Does the plan requires a member to use only a network of providers?
 - If the plan requires beneficiaries to use a network, can they only see network providers or are they allowed to also use out-of-network providers (possibly at a higher cost-sharing amount)?
 - If the beneficiary already has a primary care physician and/or sees other specialists, are those providers in the plan's network?
- Can services be obtained outside the network?
 - Is the plan an HMO-POS, PPO or PFFS ?
 - How much will the plan pay for out-of-network care in an emergency or when urgent care is needed?
 - Does the plan offer benefits for when members are traveling away from home?
- Does the MA plan include prescription drug coverage (Part D)?
 - Are the beneficiary's drugs on the formulary?
- What additional services are offered?
- What are the restrictions on when a member can change their plan?
- Is the plan's star rating 3.5 or higher?
- Is the beneficiary entitled to other coverage, such as through the VA or TRICARE (health benefits for military families and retirees)?

MORE MEDICARE HEALTH PLAN CHOICES

There are a few different ways to get Medicare health care coverage. No matter what your client decides, they are still in the Medicare Program. All Medicare health plans must provide all Medicare-covered services. However, all Medicare health plan choices may not be available in your client's area. For the most current list of Medicare health plan choices, check the Medicare & You Handbook, or look on the Internet at www.medicare.gov/find-a-plan. A local library or senior center may have computers your client can use to get information. . Beneficiaries can also get plan information by calling 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048, 24 hours/day, 7 days/week.

ELIGIBILITY

To be eligible for one of the Medicare Advantage health plan choices:

- **A person with Medicare must have Part A (Hospital Insurance) and Part B (Medical Insurance).** If your client is not sure if they have Part A and Part B, the client can call the Social Security Administration at 1-800-772-1213 or call 1-800-Medicare (1-800-633-4227). They can also create an account at <https://www.ssa.gov/myaccount/>. They can also visit their local Social Security office.
- **A person with End-Stage Renal Disease (ESRD) cannot join a Medicare Advantage (MA) plan.** ESRD is permanent kidney failure that requires dialysis or a transplant. However, beneficiaries currently in a Medicare health plan who develop ESRD can remain in the plan they are in or enroll in another plan offered by the same company. In addition, a person with Medicare with ESRD already enrolled in an MA plan can enroll in another MA plan offered by the same organization, or with another organization, if his or her original plan terminates its Medicare contract or reduces its service area. Also if an insurer offers both an employer group health plan and a Medicare Advantage plan, a member of the employee group health plan suffering from ESRD may be able to transfer into the Medicare Advantage plan.

Note: Following a successful kidney transplant, beneficiaries entitled to Medicare because of their ESRD are still eligible for Medicare for 36 months. And within this time, during an available enrollment period, they may join a Medicare Advantage plan (with medical documentation of the transplant).

- **A person with Medicare must live in the service area of a health plan.** The service area is the geographic area where the plan accepts enrollees. For plans that require a person with Medicare to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll a member if they move out of the plan's service area. If your client is disenrolled, they are automatically covered under Original Medicare. A person with Medicare who moves to a new area may be able to join a Medicare health plan in their new area if one is available. A person who is incarcerated does not live in a plan service area.



Consumer Tip: If your client is happy with the way they get health care now, they don't have to do anything. If they do nothing, they will continue to receive their Medicare health care in the same way they always have.

MEDICARE OPTIONS

- **Original Medicare**
- **Original Medicare with a Medicare Supplement/Medigap Policy**
- **Medicare Advantage (MA) Plans:**
 - Health Maintenance Organization (HMO)
 - HMOs with Point of Service Option (HMO-POS)
 - Preferred Provider Organization (PPO)
 - Private Fee-for-Service (PFFS) Plan
 - Medicare Medical Savings Account (MSA)
 - Medicare Special Needs Plan (SNP)
- To learn about other options for individuals that are enrolled in both Medicare and Medicaid **and** that also need Long Term Care Services, see Module 17 (*Medicaid*) of the HIICAP Notebook.

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod17.pdf>

Note: Currently, all of the Medicare Advantage plan choices are available in New York State, but not all plan types are available in each county.

Original Medicare

Original Medicare is the traditional system, run by the federal government, which covers Part A and Part B services. Medicare pays its share of the bill and the person with Medicare is responsible for the Medicare cost-sharing amounts.

Cost: The monthly Part B premium, Part A and Part B deductibles, and the coinsurance. (Refer to [Module 3](#) and [Module 4](#) of the HIICAP Notebook for more information.) The need for and separate cost of a prescription drug plan (PDP) needs to be considered as well. (Refer to [Module 6](#) for more information.)

Providers: Any medical provider or hospital that accepts Medicare.

Extra Benefits: One receives all the Medicare Part A and Part B covered services, but no extra benefits.

Original Medicare with a Medicare Supplement/Medigap Policy

Original Medicare is the traditional system that covers Part A and Part B services. Medicare pays its share of the bill and the person with Medicare is responsible for the Medicare cost-sharing amounts.

A person with Medicare may purchase one of 11 standard Medicare Supplement (Medigap) plans available in New York State for extra benefits. These policies pay for many of the out-of-pocket costs under Original Medicare.

Cost: The monthly Part B premium and an additional monthly premium for the Medicare Supplement/Medigap policy. All policies cover Medicare’s hospital coinsurance amounts and most pay for Medicare’s Part A deductible. The premium varies by region and insurer. New York State is a community rated state; therefore, everyone in the same region of the state pays the same premium for the exact same policy sold by the same insurer.

Providers: Any medical provider or hospital that accepts Medicare.

Extra Benefits: The person with Medicare receives all Medicare Part A and Part B covered services. Medigap plans generally do not provide any extra benefits. However, most Medicare Supplement/Medigap Policies also cover emergency care received outside of the United States, which Original Medicare does not.

(*Refer to [Module 7 of the HIICAP Notebook](#), *Medicare Supplement Insurance/Medigap*.)

Medicare Advantage (MA) Plans

A Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you’ll still have Medicare but you’ll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare. You’ll generally get your services from a plan’s network of providers. Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your Medicare card in a safe place because you’ll need it if you ever switch back to Original Medicare.

Medicare Advantage Plans include **Health Maintenance Organization (HMO)**, **Health Maintenance Organization with Point of Service Option (HMO-POS)**, **Preferred Provider Organization (PPO)**, **Private Fee-for-Service (PFFS)**, **Medicare Medical Savings Account (MSA)**, **Medicare Special Needs Plan (SNP)**.

Cost: The monthly Part B premium. Some plans charge an extra monthly premium. Your client may also pay the plan a co-payment per visit or service. With an HMO, your client will be responsible for all charges if they go out-of-network except for emergency services, urgent care, and out-of-area dialysis.

For those enrolling in a FIDA Plan (available in certain geographic locations only and only to clients who meet other eligibility requirements) there are no deductibles, premiums, or copayments/coinsurance. A FIDA plan will *not* cost more than what your client pays today for care. If your client has Medicaid with a “spend-down” or “excess income,” they will have to continue to pay the spend-down to the FIDA plan.



Caution: Medicare Supplement/Medigap Policies do NOT work with Medicare Advantage Plans.

Providers: The choice of doctors and hospitals varies by the type of Medicare Advantage Plan. HMO plans are typically more restrictive; however, under a PPO plan, a person with Medicare may use doctors and hospitals outside of the plan’s network for an additional cost.

Extra Benefits: The person with Medicare receives all Medicare Part A and Part B covered services. Most Medicare Advantage Plans offer additional benefits not covered under Original Medicare such as dental care, eyeglasses, and hearing aids.



Caution: For hospital admissions, Medicare Advantage plan members may be subject to substantial cost-sharing, usually in the form of a daily co-payment for a limited number of days. Make sure to check the plan details regarding the hospital benefit.

Health Maintenance Organization (HMO)

An **HMO** should offer comprehensive health insurance, with fixed costs and little or no paperwork for claims submission. However, there are other considerations that need to be mentioned. The plan may require members to get referrals from a primary care physician in order to see specialists in their network. They may also change coverage and/or premiums annually. There may be additional costs such as hospital and skilled nursing facility co-payments. There may be prior authorization (approval) requirements for certain services.

Also, providers can choose to no longer participate with an HMO plan during the year. And even participating providers may decide at any point that they are not accepting new patients under the Medicare HMO plan. Generally, members are required to use *only* health care providers in the HMO plan’s network.



IMPORTANT: If a member wants to use a particular primary care doctor, check to see if he or she is accepting new patients in the plan. The doctor may be participating in the HMO but not accepting new patients in that plan. If the beneficiary is an existing patient of the doctor in the HMO, the doctor may be able to continue seeing the patient but this question should be asked before joining the plan.

HMO with Point of Service Option (HMO-POS)

An HMO with a Point of Service option, or **HMO-POS**, is an HMO where a member may receive some services outside of the plan's network of providers.

Usually, a member will pay a higher amount if they use non-network providers. There may also be limits on the types of services covered outside the plan's network. Prior authorization may be required. Check with the individual plan for details on the out-of-network coverage.

Preferred Provider Organization (PPO)

A PPO must have a network of providers so that enrollees can get all services within the plan. The main difference between a PPO and an HMO is that PPO enrollees are not required to use only network providers. Also, with a PPO, a member does not have to get a referral to see a specialist.

Medicare Advantage plans, including PPOs, must offer all of Medicare's required benefits. They may also offer additional benefits, such as dental care, eyeglasses or hearing aids.

PPOs have networks of preferred providers (hospitals, physicians and other providers) who provide all of the basic Medicare benefits, like Medicare HMOs. In addition, unlike HMOs, PPOs provide some coverage for services provided outside of their network. Cost-sharing amounts will usually be lower when beneficiaries use network providers than when they use out-of-network providers. Premiums are usually more than HMO premiums, but less than premiums for Medicare Supplement Insurance.

Note: Some companies may offer a Regional PPO (RPPO) that serves the entire state of New York, rather than select counties. Currently, United Healthcare is the only company offering a RPPO in New York State. Other companies may offer PPO plans in only certain counties of the state.



Caution: People with Medicare who are enrolled in an HMO, HMO-POS, or PPO plan who want Part D drug coverage must get it through the same plan. They cannot purchase a separate stand-alone Part D plan (PDP). Doing so would cause them to be disenrolled from their Medicare Advantage plan.

Private Fee-for-Service Plan (PFFS)

Under a PFFS plan, a person with Medicare may go to any Medicare-participating medical provider or any hospital as long as the provider or hospital accepts the plan's payment terms. PFFS plans also have networks of providers and are very similar to PPO plans. No referrals are necessary.

And like other Medicare Advantage plans, the person with Medicare may receive extra benefits Original Medicare doesn't cover.

Cost: The monthly Part B premium, any monthly premium the Private Fee-for-Service plan charges, and an amount per visit or service.

Providers: Can go to any network provider or any Medicare-participating medical provider or hospital that accepts the PFFS plan.

Extra Benefits: The person with Medicare receives all Medicare Part A and Part B covered services. PFFS plans may offer additional benefits Original Medicare doesn't cover.



Caution: PFFS plan members should check to make sure their doctors, hospitals, and other providers will agree to treat them under the plan and that they will accept the PFFS plan's payment terms.

Note: Prescription drug coverage (Part D) may be included in the PFFS plan. But if the PFFS plan does not include drug coverage, a person with Medicare can also enroll in a separate stand-alone Medicare Prescription Drug Plan (PDP).

Medicare Medical Savings Account (MSA)

Medicare MSA plans combine a high deductible Medicare Advantage plan with a medical savings account. The plan deposits an amount annually into an account which can be used for medical expenses. Any unused portion can be carried over to the next year. Once the high deductible is met, the plan pays 100% of covered expenses. Preventive services may not be subject to the deductible and coinsurance. MSA plans do not have a provider network. MSA plan members can use any Medicare provider.

The medical savings account can also be used to pay for non-Medicare covered medical expenses such as for dental care, vision or hearing aids, but only payments made for Medicare (Part A and Part B) covered expenses will be credited toward the plan deductible.

Note: If a person with Medicare is in a Medicare MSA Plan, they cannot leave their plan (disenroll) during the January 1 – March 31 open enrollment period. If they choose a Medicare MSA Plan for the first time during the Annual Coordinated Election Period and then change their mind, they can cancel their enrollment by December 15 of the same year. They still only have until December 7 to join another health or drug plan. After December 7 and up to December 15, the beneficiary can only return to Original Medicare.

- <https://www.medicare.gov/Pubs/pdf/11206.pdf>

Note: Prescription drug coverage (Part D) is not included in the MSA plan. A person with Medicare in an MSA plan must enroll in a separate stand-alone Medicare Prescription Drug Plan (PDP) in order to have drug coverage under Medicare.

Medicare Special Needs Plan (SNP)

A Medicare SNP is a type of Medicare Advantage plan that is only available for certain Medicare beneficiaries, such as those with both Medicare and Medicaid (or who are enrolled in a Medicare Savings Program), institutionalized beneficiaries, or those with certain chronic conditions. SNPs may offer more focused and specialized health care as well as better coordination of care for these beneficiaries than other types of Medicare Advantage plans. All SNPs include Part D drug coverage.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare program for older adults and people over age 55 living with disabilities. This program provides community-based care and services to people who would otherwise need nursing home-level care. PACE provides all the care and services covered by Medicare and Medicaid, as well as additional care and services not covered by either program. Beneficiaries with either Medicare or Medicaid or both can join a PACE plan. They must live in the service area of a PACE organization.

Note: PACE plans are not considered Medicare Advantage Plans

Counseling Beneficiaries about MA Plans

HIICAP counselors cannot endorse a particular Medicare Advantage (MA) plan, but can help clients get information needed to decide if an MA plan meets their needs.

Detailed information on Medicare Advantage options is available at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week.

Fully Integrated Duals Advantage (FIDA) Plan

Who is eligible for the FIDA program?

Since FIDA builds upon the existing Managed Long Term Care (MLTC) program, the vast majority of people enrolled in an MLTC Plan are also eligible for a FIDA Plan. *In general*, individuals must:

- Reside in a geographic location that offers a FIDA plan; *and*
- Be 21 years of age or older; *and*
- Be entitled to Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Part D, and receiving full Medicaid benefits; *and*
- Require community-based long-term services and supports (LTSS) for more than 120 days per year or be eligible for, but not already receiving, facility-based or community-based LTSS (“New to Service”).

Please refer to Module 17 (*Medicaid*) of the HIICAP Notebook for a full description of MLTC.

- <https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod17.pdf>

When can individuals enroll in FIDA Plans?

Generally, eligible individuals can enroll in FIDA Plans at any time. Those individuals who are passively enrolled (enrolled by the state) will receive notices indicating the name of their FIDA Plan along with important information about the program and the phone number to call if they have questions or want to opt out.

Is FIDA mandatory for dually eligible participants in New York State?

No. FIDA is not mandatory for anyone in New York State. Individuals can opt out of FIDA at any time.

If you join the FIDA program, you will:

- **Get full Medicare and Medicaid coverage, long term care services, Part D and Medicaid drugs, and additional benefits from a single, integrated managed care plan.** In other words, FIDA covers all the benefits that you would receive through your Managed Long Term Care (MLTC) plan, Original Medicare or a Medicare Advantage plan, and your Part D prescription drug plan.
- **Pay no deductibles, premiums, or copayments/coinsurance.** A FIDA plan will *not* cost you more than what you pay today for your care. (If you have Medicaid with a “spend-down” or “excess income,” you will have to continue to pay your spend-down to the FIDA Plan.)

- **Be able to access specialists directly.** No need for provider referrals.
- **Have a dedicated person (a “Care Manager”)** who can schedule doctor’s appointments, arrange transportation and help you get your medicine. (In most cases, if you already have a care manager through your MLTC plan, you will keep your current care manager.)
- **Have Medicare and Medicaid doctors and specialists as participants on your care team.** They will spend time with you, your caregivers or anyone you trust to discuss the care you may need. In addition, they will have time to share their expert opinions with each other and coordinate your care.
- **Use one FIDA Plan phone number for all questions regarding your health care benefits.** You will no longer need to make separate calls to 1-800 Medicare, your Medicare health or drug plan, and your current Medicaid plan about your coverage.
- **Have the right to leave FIDA at any time and for any reason.** If you decide to do so, you will continue to receive all of your Medicaid long term care benefits through the MLTC program and all of your Medicare benefits through Original Medicare or a Medicare Advantage plan, and a Part D plan.

MEDICARE ADVANTAGE (MA) ENROLLMENT PERIODS

Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual’s first entitlement to **both** Medicare Part A and Part B and ends on the later of:

- The last day of the individual’s Part B initial enrollment period or
- The last day of the month preceding the individual’s entitlement to both Part A and Part B

Annual Coordinated Election Period (AEP)

Eligible Medicare beneficiaries can enroll in a Medicare Advantage plan or switch their plan choice (either Medicare Advantage or Prescription Drug Plan) during the Annual Coordinated Election Period, which runs every year from October 15 to December 7. Any election made during this period will be effective the following January 1.

NEW: Medicare Advantage Open Enrollment Period (OEP)

During the OEP (January 1 – March 31), beneficiaries enrolled in a Medicare Advantage plan (with or without prescription drug coverage) have one opportunity to switch to Original Medicare or another Medicare Advantage plan. The change would be effective the first of the following month (February 1, March 1, or April 1). If they switch to Original Medicare or to a Medicare Advantage plan without prescription drug coverage, beneficiaries then have a coordinated special enrollment period to join a Medicare Part D prescription drug plan. Beneficiaries can sign up for a stand-alone prescription drug plan even if their former MA plan did not include Part D drug coverage.

A similar provision applies to individuals who are newly entitled to both Medicare Part A and Part B on a date other than January 1 and who are enrolled in a Medicare Advantage plan. These beneficiaries may change their Medicare Advantage plan once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the third month of the entitlement. They are entitled to the same coordinated special enrollment period for Part D prescription drug coverage as described above for the OEP.

Note: Unlike other types of MA plans, beneficiaries enrolled in an MSA plan cannot use the Open Enrollment Period to disenroll from the plan and return to Original Medicare.

Medicare Advantage Disenrollment Period (MADP)

The MADP was abolished and replaced by the OEP beginning in 2019.

Special Enrollment Period (SEP)

A Special Enrollment Period (SEP) is an exception where people with Medicare may be able to enroll, disenroll or switch their Medicare Advantage plan outside of the other enrollment periods. An SEP may be available for a number of different reasons including for a change in residence or loss of an employer/retiree plan, or for people with Medicare who enroll in a MA plan when first eligible for Medicare at age 65.

5-star Special Enrollment Period

A beneficiary can switch to a Medicare Advantage Plan, Medicare Cost Plan, or Medicare Advantage Plan with prescription drug coverage that has an overall 5-star rating from December 8 to November 30. Beneficiaries can only use this Special Enrollment Period once during this time frame. There are no 5-star MA plans in New York State in 2018.

IMPORTANT: Beneficiaries may lose their prescription drug coverage if they move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't. They will have to wait until the next Annual Coordinated Election Period to get drug coverage and may have to pay a late enrollment penalty. If a beneficiary's Medicare Advantage Plan includes prescription drug coverage and the beneficiary joins a Medicare Prescription Drug Plan, the beneficiary will be disenrolled from his or her Medicare Advantage Plan and returned to Original Medicare.

SEP65

People with Medicare who enroll in an MA plan (other than an MSA plan) during the Initial Enrollment Period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from this MA plan and elect Original Medicare any time during the 12-month period that begins on the effective date of coverage in the MA plan.

IMPORTANT: Unless the beneficiary qualifies for a Special Enrollment Period (SEP), enrolling in or switching to a different MA plan can only be done during the Annual Coordinated Election Period (AEP) (October 15 – December 7) or the Medicare Open Enrollment Period (OEP) (January 1 – March 31). Beneficiaries can also return to Original Medicare during the OEP. (The OEP does not apply to MSA plans as previously noted on pages 7 and 10.)



Caution: Beneficiaries simply not paying their MA plan premiums does not guarantee that the beneficiaries will be disenrolled from their MA plan and returned to Original Medicare.

What if a person with Medicare no longer wants to be in an MA plan?

If a person with Medicare wants to disenroll from an MA plan, they can send a signed request to the plan, but are not required to do so. The beneficiary could also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week, to disenroll when eligible.

When a person with Medicare returns to Original Medicare, it may be advisable to purchase Medicare Supplement (Medigap) insurance and to enroll in a Medicare Part D prescription drug plan.

Important: If an MA plan member joins a different MA plan, he or she will automatically be disenrolled from the first MA plan upon enrollment in the new MA plan. And if a member of a Medicare Advantage plan that includes prescription drug coverage enrolls in a stand-alone Part D prescription drug plan (PDP), he or she will be automatically disenrolled from the MA plan and returned to Original Medicare.

WHAT TO CONSIDER BEFORE JOINING A MEDICARE ADVANTAGE PLAN

Refer to the www.medicare.gov Web site or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week for the most recent listing of Medicare Advantage (MA) plans available in a county. If your client lives in a county served by more than one MA plan, they can compare benefits, costs and other features to find which plan best suits their needs at a price they can afford. (By using the Medicare Plan Finder at www.medicare.gov/find-a-plan, counselors and people with Medicare can acquire the information needed.)

A person with Medicare should ask each MA plan for a copy of their Summary of Benefits and Evidence of Coverage. Beneficiaries should never rely on advertisements and should check the Star Ratings for any plan they are interested in. The client needs to learn about their rights and the nature and extent of coverage. After the information is reviewed, one should ask:

Cost: What is the MA plan’s monthly plan premium? What co-payment(s) will I have to pay?

A person with Medicare will have to continue to pay their Medicare Part B premium. Some MA plans charge a premium in addition to the Medicare Part B premium, while others do not. MA plans usually charge a co-payment when services are received.

Additional Services: Does the MA plan offer services in addition to those covered under Original Medicare?

All MA plans must provide the same basic health benefit package available under Original Medicare. Most plans also offer limited coverage for dental care, hearing aids and eyeglasses. Most MA plans also offer Medicare Part D (Medicare Prescription Drug Coverage) to their members. (See Module 6 for details.) <https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod6.pdf> Find out by asking about additional services: What benefits are available for a routine physical; vision care; dental care; hearing; home care; chiropractic; foot care; nursing home; house calls; mental health services?



Reference: If the counselor or person with Medicare does not have access to the Internet to view the Medicare Plan Finder at www.medicare.gov/find-a-plan, they may check their Medicare & You Handbook or call 1-800-MEDICARE, 24 hours a day/7 days a week, for a listing of county specific Medicare Advantage plans.

Additional Considerations for HMO Plan Members

Care outside the HMO network

What if a member wants to receive health care services outside the HMO, or wants to get a second opinion outside the HMO, or needs to see a specialist that does not contract with the HMO?

Neither the HMO nor Medicare will cover care outside the HMO network except for: emergency or urgently needed care or for out-of-area dialysis care. In addition, HMOs need to cover out-of-network specialist care if they do not have an in-network specialist. However, a referral from the primary care physician and prior authorization from the HMO is still required.

Emergency Care

What is a medical emergency? How do members get emergency care if they are in a Medicare HMO Plan?

An Emergency Medical Condition is defined as a “medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual (or in the case of a pregnant woman, the health of the unborn child)
2. Serious impairment to bodily functions
3. Serious dysfunction of any body organ or part”

HMOs are required to provide access to emergency and urgently needed care services 24 hours a day, 7 days a week. The plan must pay for emergency care and cannot require prior authorization for emergency care received from any provider. A person with Medicare can receive emergency care anywhere in the United States. When a beneficiary receives emergency care, the doctor or hospital that provides the service should bill their HMO. If the beneficiary receives the bill, they should send it to the HMO and keep a copy for their own record.

Following a medical emergency, the HMO must also pay for necessary care before the condition is stable enough for the beneficiary to return to their plan’s provider. If their condition lets them return to the plan’s service area, they will need to get follow-up care from their Medicare HMO plan provider.

A beneficiary (or a family member or friend) should let the plan know of emergencies as soon as medically possible. If what the beneficiary believed was an emergency turns out not to be, the plan must still pay. A member should always appeal a denial of payment for emergency services. Refer to Module 10 (Medicare Claims and Appeals) of the HIICAP Notebook.

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod10.pdf>

Urgently Needed Care

What is “urgently needed care?” How does a member get urgently needed care if in a Medicare HMO Plan?

Urgently needed services are defined as covered services provided when a beneficiary is temporarily absent from the HMO’s service area, (or, under unusual and extraordinary circumstances, provided when the beneficiary is in the service area but their contracting medical provider is temporarily unavailable or inaccessible) and when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury, or condition; and
2. It is not reasonable given the circumstances to obtain the services through the contracting medical provider.

Care outside the United States

Under what conditions will the HMO pay for health care if a member is traveling outside the United States?

Generally, Original Medicare will not pay for care outside the United States, but Medicare HMO plans may cover worldwide emergency care as an additional benefit. It is important to inquire about this before making travel arrangements to avoid unnecessary medical bills.

CHOOSING THE MEDICARE ADVANTAGE OPTION

Medicare Advantage (MA) plans provide all Medicare-covered services and receive payment directly from Medicare for the care a person with Medicare needs. MA plans also provide additional benefits. For instance, most MA plans offer limited coverage for dental care, hearing aids and eyeglasses.

If a person with Medicare joins a Medicare HMO plan, they must obtain services from the health care professionals and facilities that are part of the HMO plan network except for emergency or urgently needed care, or out-of area dialysis care. The person with Medicare selects a primary care physician (PCP) from those affiliated or under contract with the HMO plan. That doctor coordinates your client’s care by providing health care and arranging for them to see other providers when necessary.

If your client enrolls in any type of Medicare Advantage (MA) plan, they must continue to pay their Part B monthly premium including any Part B or Part D Income Related Adjustment Amount (IRMAA). This is the premium that is usually withheld from their monthly Social Security check. Your client may also have to pay co-payments when they see a provider and a monthly premium to the MA plan. In return, the MA plan provides your client with all Medicare hospital and medical benefits.

A person with Medicare will not need a Medigap policy if they join a Medicare Advantage plan since they will not be able to collect on the Medigap policy benefits. If your client already has a Medigap policy to supplement their fee-for-service Medicare coverage and they decide to join a Medicare Advantage plan, they should be advised to discontinue their Medigap policy, because it is not needed.



Caution: Please note that if your client has a retiree plan (including employer sponsored MA and PDP plans), they should be very cautious about giving it up to join a Medicare Advantage plan instead because in most cases, they will not be able to get this retiree plan benefit back again.

Who can enroll in a Medicare Advantage plan?

Most Medicare beneficiaries are eligible to enroll. A person with Medicare can enroll in a Medicare Advantage plan if they:

- live in the plan's service area
- are enrolled in both Medicare Part A and Part B
- do not have End-Stage Renal Disease (ESRD) before they join

Medicare Advantage (MA) plans cannot delay coverage for preexisting conditions. And a person with Medicare cannot be rejected because of their age or health status (except for ESRD).

WHY JOIN A MEDICARE ADVANTAGE PLAN?

Predictable Payments and Lower Costs

Medicare Advantage (MA) plans minimize out-of-pocket payments and have predictable co-payment amounts. These features may give a person with Medicare more control over their health care costs.

ALL Medicare Advantage plans must have yearly Maximum Out-of-Pocket (MOOP) amounts for all Part A and B covered services, not to exceed \$6,700 (HMO) and \$10,000 (PPO), including \$6,700 in-network. Although these are the highest amounts that plans may have, many MA plans have a much lower MOOP. (MOOP does NOT include the plan premium, any cost-sharing for extra benefits not covered by Medicare and any Part D drug cost-sharing.) Once a beneficiary has reached the MOOP, Part A and B covered services are provided at 100%.

Note: MA plans must provide all in-network preventive services that are covered at zero cost-sharing under Original Medicare at zero cost-sharing. This means no deductible and no co-pay.

People with Medicare enrolled in a Medicare Advantage plan also do not need Medigap insurance, since MA plans provide all or most of the benefits provided by Medicare and a Medigap policy.

Note: In New York State if a person with Medicare enrolls in an MA plan and later returns to Original Medicare, they will be able to buy a Medigap insurance policy regardless of age or health status at any time. However, there could be a pre-existing condition waiting period if there is more than a 63-day lapse in coverage.

More Benefits

Medicare Advantage (MA) plans offer benefits that are not available under Medicare's fee-for-service program. For example, MA plans may offer limited coverage for dental care, hearing aids, and eyeglasses.

Less Paperwork

Another advantage is that a member usually does not have to fill out claim forms for services provided. They simply show their membership card, pay the required co-payment and receive services. A member does not have to complete any paperwork.

The only exception is if a member pays out-of-pocket for **emergency** or **urgently needed** care. Then they may have to send a claim form and other information to the MA plan for payment or reimbursement.

Educational Services

Medicare Advantage plans often provide ongoing health education classes and information to encourage healthier lifestyles.

Tool to Help with Decision-Making

The Medicare Plan Finder can help make health plan choices. This service is on www.medicare.gov on the Web or one can call 1-800-MEDICAR(E). Callers can speak with a customer service representative at 1-800-MEDICAR(E) 24 hours a day, including weekends.

QUALITY OF CARE

Medicare Advantage plan quality comparison information is available in the Medicare Plan Finder section of the Medicare web site (www.medicare.gov). Plans receive an overall rating of 1 (poor) to 5 (excellent) stars. If you want more detail, you can see the actual numbers or percentages that go into each of 5 different categories that make up these overall ratings. These categories include:

- **Staying healthy: screenings, tests, and vaccines.** Includes whether members got various screening tests, a yearly flu shot, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions.** Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- **Member experience with the health plan.** Includes ratings of member satisfaction with the plan.
- **Member complaints, problems getting services, and improvement in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members filed complaints against the plan and choose to leave the plan. Includes how much the plan's performance has improved (if at all) over the last two years.
- **Health plan customer service.** Includes how well the plan handles calls from members, makes decisions about member appeals for health coverage, and handles new enrollment requests in a timely way.

People with Medicare may also wish to check with the New York State Department of Financial Services at **1-800-342-3736** to see if complaints have been filed against the health insurer that offers the Medicare Advantage plan.

Note: Complaints about the quality of care received from Medicare providers should be directed to the Quality Improvement Organization (QIO) in New York State, **Livanta**, at **1-866-815- 5440**.

<http://bfccqioarea1.com/>

APPEAL RIGHTS

Refer to Module 10 (*Medicare Claims and Appeals*) for information on appealing a denial of coverage for services provided to Medicare Advantage plan members.

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod10.pdf>

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

1-800-MEDICAR(E) **1-800-633-4227**

www.medicare.gov 24 hours day/7 days a week

NY Connects **1-800-342-9871**

LIVANTA, LLC **1-866-815-5440**

BFCC-QIO

9090 Junction Dr. Suite 10

Annapolis Junction, MD 20701

<http://bfccqioarea1.com/states/ny.html>

Additional Resources

- *A Quick Look at Medicare*, CMS Publication #11514
 - <https://www.medicare.gov/Pubs/pdf/11514-A-Quick-Look-at-Medicare.pdf>
- *Your Guide to Medicare Special Needs Plans (SNPs)*, CMS Publication #11302
 - <https://www.medicare.gov/Pubs/pdf/11302.pdf>
- *Your Guide to Medicare Medical Savings Account Plans*, CMS Publication #11206
 - <https://www.medicare.gov/Pubs/pdf/11206.pdf>
- *Quick Facts About Programs of All-inclusive Care for the Elderly (PACE)* - CMS Publication #11341
 - <https://www.medicare.gov/Pubs/pdf/11341-PACE.pdf>
- **FIDA Program Resources**
- <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/New-York.html>
- The Memorandum of Understanding can be found at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf>
- Additional information on the ongoing development and implementation of the New York demonstration is available at: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm
- NY Medicaid Choice at [1-800-505-5678](tel:1-800-505-5678), or visit www.nymedicaidchoice.com.
- FIDA’s Ombudsman Office – Independent Consumer Advocacy Network (ICAN) at [1-844-614-8800](tel:1-844-614-8800) or visit www.icannys.org

STUDY GUIDE MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS



Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.



What do all Medicare Health Plans have in common?



2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?



In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare program.
- All Medicare Health Plans **must** provide all Medicare-covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, must not have End-Stage Renal Disease (ESRD) and must live in the service area of the MA plan.
- Not all of the Medicare Advantage Health Plan Choices are available in all areas.
- People with Medicare must be advised of when they can enroll in a Medicare Advantage plan, switch to Original Medicare or change to another MA plan.
- If your client is happy with the way they get health care now, they do not have to do anything. Your client will continue to receive their Medicare health care in the same way they always did.

ANSWER KEY MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS



Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.



What do all Medicare Health Plans have in common?

All Medicare Health Plans must provide all Medicare-covered services.



2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?

Because a person with Medicare may receive extra benefits that Original Medicare does not offer such as dental benefits, hearing aids, eyeglasses and more. With an MA plan, a person with Medicare does not need a Medicare Supplement/Medigap plan and their payments may be more predictable and more limited.



In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare Program.
- All Medicare Health Plans **must** provide all Medicare-covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, must not have End-Stage Renal Disease (ESRD) and must live in the service area of the MA plan.
- **Not** all of the Medicare Advantage Health Plan Choices are available in all areas.
- People with Medicare must be advised of when they can enroll in a Medicare Advantage plan, switch to Original Medicare or change to another MA plan.
- If your client is happy with the way they get health care now, they do not have to do anything. Your client will continue to receive their Medicare health care in the same way they always did.