

Medicare Advantage Plans

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Consider Your Medicare Options



More than 43 million people are covered by the Medicare program. People with Medicare can get their coverage through original Medicare (the traditional fee-for-service program) or from Medicare private plans (the Medicare Advantage program). Today, more than six million people with Medicare are enrolled in a Medicare private plan (HMO, PPO, PFFS, SNP, MSA). Most people with Medicare who have joined a

Medicare private plan are in health maintenance organizations (HMOs), which have been available under Medicare since the mid-1980s.

Tip

Medicare Advantage plans may offer more benefits than traditional Medicare, but may limit your ability to get care from the doctor or hospital of your choice, depending on the plan you select.

To make an informed decision, you need to first understand how these health plans work and how they differ, then decide which option is best for you. Here is a brief description of each of the Medicare options.

Original Medicare

If you choose coverage under the traditional fee-for-service Medicare program, you can generally get care from any doctor or hospital you want and receive coverage for your care anywhere in the country. However, traditional Medicare has high cost-sharing requirements and does not currently cover the costs of certain services. To help pay for uncovered benefits and to help with Medicare's cost-sharing requirements, many people in the traditional Medicare program have supplemental insurance (see [Health Insurance to Supplement Medicare](#)).

Medicare Private Plans

Medicare HMOs

Medicare HMOs cover the same doctor and hospital services as the original Medicare program, but out-of-pocket costs for these services are usually different. HMOs appeal to some people with Medicare because they may provide additional benefits, such as eyeglasses, which are not covered by the traditional Medicare program. Medicare HMOs may charge a premium that you would need to pay in addition to the Part B monthly premium.

You should be aware that Medicare HMO enrollees generally can only use doctors, hospitals, and other providers in the HMO's network. For an additional fee, some HMOs offer point-of-service (POS) benefits that partially cover care received outside the network.

If you join a Medicare HMO, you will usually have to select a primary care doctor who is responsible for deciding when you should see a specialist and which specialist you should see.

Neither Medicare nor the HMO will pay for unauthorized visits to specialists in the plan, providers outside the HMO's network, or for non-emergency care outside the HMO's service area.

Medicare PPOs

Medicare PPOs, or "Preferred Provider Organizations," are private health plans, much like Medicare HMOs. HMOs and PPOs differ in two key ways:

1. Medicare PPOs cover some of the costs of your care if you use doctors and hospitals outside the network.
2. Medicare PPOs generally do not require that you see a primary care physician before going to a specialist.

Regional PPOs became available under Medicare in 2006. These plans are similar to local Medicare PPOs, but serve a larger geographic area (either a single state or multi-state area) and must offer the same premiums, benefits, and cost-sharing requirements to all beneficiaries in the region. Regional Medicare PPOs offer all Medicare benefits, including the prescription drug benefit, but unlike traditional Medicare, these plans have a single deductible for hospital and physician services and an annual out-of-pocket limit on cost sharing for benefits covered under Parts A and B of Medicare. Keep in mind that the out-of-pocket limit will vary depending on the plan you select. As with local PPOs, individuals who sign up for a regional PPO will typically pay more if they go to providers outside of the network.

Private Fee-for-Service (PFFS) Plans

Private fee-for-service plans cover Medicare benefits like doctor and hospital services, much like Medicare HMOs and PPOs. Unlike Medicare HMOs and PPOs, private fee-for-service plans do not have a formal network of doctors and hospitals. Still, not all doctors and hospitals are willing to treat members of a private fee-for-service plan. If considering enrolling in a private fee-for-service plan, make sure your doctor and hospital are willing to accept the private fee-for-service plan's payments for services before you enroll. Also, be sure you understand a plan's benefits and cost sharing requirements before you enroll because private fee-for-service plans decide how much enrollees pay for Medicare-covered services and may charge higher cost sharing for certain health care services than the original Medicare program. Private fee-for-service plans are not required to offer the Medicare drug benefit, but many do. If you enroll in a private fee-for-service plan without drug coverage, you can also enroll in a Medicare stand-alone prescription drug plan for your drug coverage.

Special Needs Plans (SNPs)

Special needs plans are private plans that provide Medicare benefits, including drug coverage for beneficiaries with special needs. These include people who are eligible for both Medicare and Medicaid, those living in certain long-term care facilities (like a nursing home), and those with severe chronic or disabling conditions.

For additional information about Medicare Advantage plans, call 1-800-MEDICARE, or get information about Medicare options in your area on the Medicare Personal Plan Finder website, <http://www.medicare.gov/MPPF/home.asp>.

Medicare Medical Savings Accounts (MSAs)

Beginning January 1, 2007, people on Medicare will have access to a new consumer-driven Medicare Advantage product called a Medicare Medical Savings Account (MSA). The new MSA option has two parts. The first part is a Medicare Advantage health plan with a high deductible. The second part is a medical savings account into which Medicare deposits an annual amount that can be used to pay health care costs.

Here is how the Medicare MSAs and high deductible health plans work:

- Medicare makes an annual deposit into an interest-bearing account to help beneficiaries pay their health costs. The money in the account can be used to pay for most medical services, which are considered qualified medical expenses, including the deductible for the high deductible health plan. Beneficiaries may not contribute their own funds to the account.
- High deductible health plans cover all Medicare Part A and Part B benefits. They may also cover additional benefits at an extra cost but no plans offer supplemental benefits in 2007. There is no monthly premium for these plans, however, beneficiaries are still required to pay the Part B monthly premiums.
- A beneficiary enrolled in this type of plan must meet an annual deductible (max \$9,500 in 2007) before the plan will begin to pay for health care expenses. After the deductible is met, the plan is responsible for all Medicare-covered services other than prescription drugs.
- At the end of the year, if any amount of the deposit into the MSA account is unspent, it remains the property of the beneficiary and can be rolled over to cover costs incurred in the following year.
- MSA/high deductible health plans do not cover Part D prescription drugs. However, beneficiaries with this coverage may enroll in a stand-alone prescription drug plan (PDP). The funds in the MSA account cannot be used to pay Part D premiums, but can be used to pay for Part D co-payments, coinsurance and deductibles tax-free. However, funds withdrawn from an MSA account to pay for Part D drugs do not count toward the beneficiary's true out-of-pocket costs.

Medicare Advantage and Prescription Drugs

All companies offering Medicare Advantage plans must offer prescription drug coverage in at least one of their plans. Medicare Advantage plans with drug coverage may vary in their premiums, deductibles, formularies and cost-sharing, depending on the type of Medicare Advantage plan you select. See the [Medicare and Prescription Drug](#) section for more information.

Know What You Want from a Medicare Plan

Whether original Medicare, a Medicare HMO, or another private Medicare plan is right for you will depend on your unique needs and circumstances. Think about what is most important to you when you are healthy and when you are sick. Here are some topics to consider:

Receiving care from the doctor and hospital of your choice

Under original Medicare, you can use whichever specialists and hospitals you choose, whenever you need, and without a referral from another doctor. Medicare private plan options could limit your ability to get care from the doctor or hospital of your choice, or there may be extra charges for out-of-network care. If provider choice is a priority, you should consider original Medicare with added protection from a Medicare supplemental insurance policy, sometimes known as Medigap, or from an employer-sponsored or union retiree health plan, if you are eligible (see [Health Insurance to Supplement Medicare](#)).

Getting coverage of additional benefits to reduce your medical costs

If you are on a tight budget and are willing to limit your choice of doctors and hospitals, you may be able to reduce your health care expenses and get coverage of additional benefits through a Medicare Advantage plan. It is important to review the scope and limits of additional benefits when choosing among available plans. It is also important to look at how much your out-of-pocket costs will be if you get sick. For example, some Medicare private plans charge a copay for each day of an inpatient hospital stay, while original Medicare charges only a deductible but no daily copays for the first 60 days of a hospital stay.

Maintaining health care coverage while away from home

Under original Medicare, you will be covered for care anywhere in the United States. While private plans must cover emergency care for members outside the plan area, most do not cover other health care services while away from home. For example, Medicare HMOs have more restrictive networks of doctors and hospitals that limit coverage away from home.

Keeping supplemental coverage from a former employer or union

If you are considering joining a Medicare private plan (either a Medicare Advantage plan or a stand-alone prescription drug plan), you should talk to your employer or former employer to be sure you won't lose valuable retiree health benefits if you sign up for a private plan. Many employers offer retiree health coverage as a supplement to traditional Medicare; some also offer coverage through Medicare HMOs and other private plan options.

Coordinating with Medicaid benefits

If your income and assets are quite modest, you may qualify for Medicaid benefits or other special programs that will help pay some of your health care costs. For those who qualify, Medicaid often pays for valuable benefits, such as nursing home care, and also pays Medicare's premiums. If you are already covered by Medicare and Medicaid, you should find out what you must pay to join a Medicare private plan and whether Medicaid will cover the plan's copayments. Contact information for your state Medicaid office can be found in the [Additional Resources](#) section of this guide.

Changing your mind

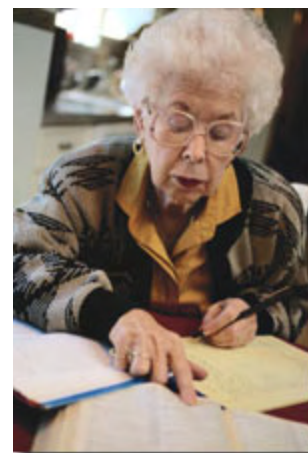
In 2007 and future years, the open enrollment period to switch Medicare Advantage plans will be limited to just the first three months of the year. For stand-alone prescription drug plans, the open enrollment period runs from November 15 through December 31 of each year. If you are also eligible for Medicaid, you can switch plans at anytime.

If you enroll in a Medicare private plan that later stops serving people with Medicare, you can always return to original Medicare, the traditional fee-for-service program, or you can enroll in another Medicare Advantage plan.

Compare Medicare Advantage Plans Offered Where You Live

If you are happy with your original Medicare coverage you can stick with it. You can keep your coverage through your Medicare private plan if the plan continues operating in your area from year to year. If you think you may want to change, the next step is to find out which plans are offered where you live. While original Medicare is available in all parts of the U.S., certain types of private plans may not be. In some areas of the U.S., people with Medicare have a limited choice of private plans available, while in other areas, there are multiple Medicare private plans from which to choose.

For a list of plans in your area and a copy of the Medicare handbook, *Medicare & You*, call Medicare at 1-800-MEDICARE or visit Medicare's website at www.medicare.gov. For free help in understanding differences among Medicare plans, you can call your State Health Insurance Assistance Program (SHIP). Contact information for your state's SHIP is found in the Medicare handbook and in this guide under [Additional Resources](#).



You should consider four important factors before signing up for a plan:

1. Accessibility of doctors and hospitals

Can you continue to see the doctors you know and trust if you join a certain plan? Your doctor or specialist might be in one plan's network, but not in another's. Even if your doctor is in a plan's network, he or she can leave that network at any time. What about your choice of hospital?

2. Extra benefits

The supplemental benefits offered by Medicare private plans vary widely and may change every year. If you want to join a plan because of the prescription drug benefit, make sure that the plan covers the drugs you need and you understand any limits that may apply.

3. Cost

How much are the monthly premiums and copayments associated with different health care services? Is there a deductible? Keep in mind that costs generally change each calendar year.

4. Quality and reputation

Not all Medicare private plans are not the same. Review each plan's written information and try to talk to plan members about their experiences. For information on quality and performance, visit Medicare's website at <http://www.medicare.gov/MPPF/home.asp>.

Know your rights

No matter which plan you choose – original Medicare, a Medicare HMO, or another Medicare private plan – understand your rights as a patient and a consumer. If you believe you have been unfairly denied any Medicare-covered benefits, you have the right to appeal. You should send a copy of the denial notice and, if possible, a letter from your doctor explaining your need for the denied service and a letter requesting a review to the company that issued the denial.