

THE HIGHLIGHTS: Medicare Advantage – Private Fee for Service Plans

Medicare’s Private Fee for Service (PFFS) health plans are one type of Medicare Advantage Plan (Part C). PFFS plans are not linked to the actual service provision but are a payment system for beneficiaries to utilize Medicare providers who agree to the plan’s terms. Unlike managed care plans that coordinate care for the beneficiary through primary care physicians and/or specialists through referral within a network of providers, PFFS plans do not have a network. **Since there is no network, there is no contractual obligation by physicians, hospitals, or any other care facilities to accept the plan’s payment terms. PFFS plans do not manage or coordinate care, they provide a payment system for Medicare health care access.** This chart highlights the most significant differences between Original Medicare, Medicare Advantage Coordinated Care plans (such as HMOs and PPOs), and Private Fee for Service Medicare Advantage Plans.

HEALTH INSURANCE	COVERAGE	COST	CONCLUSION
Original Medicare	Care is received from any Medicare participating provider without restriction = no network. Beneficiaries who wish to have Medicare drug coverage must join a free-standing PDP.	Part A entitlement or buy-in. Part B monthly premiums and any co-insurance under Original Medicare. (Private monthly or quarterly costs for Medigap supplemental insurance.) Part D monthly premiums, deductible, and any co-pays or coinsurance for drugs.	Beneficiaries control how and when to access the health care system, including both outpatient and inpatient care. Appeals are filed with Medicare.
MA or MA-PD Coordinated Care Plans (HMOs, PPOs, etc)	Medicare pays a set amount to the plan to manage and coordinate care. Care is only covered by the MA or MA-PD plan from providers who have contracted with the plan = in network. Generally, out of network care is not covered by the plan, except for urgent or emergency care needs. Plans that do allow for out of network benefits may have coverage restrictions and higher associated costs. Beneficiaries who wish to have Medicare drug coverage must enroll in an MA-PD.	In addition to the Part B premium, there can be plan premiums, co-pays or coinsurance, deductibles. Out-of-network costs vary depending on the rules of the plan. Part D monthly premiums, deductible, and any co-pays or coinsurance for drugs.	Care is received through health plan providers with contractual obligations = in network. Plans have a set service structure to determine what inpatient and outpatient care is covered in addition to Medicare benefits. Appeals are filed with the plan first.
MA or MA-PD Private Fee for Service Plans (PFFS)	Medicare pays a set amount for each beneficiary to the plan that establishes health care payment arrangements with Medicare participating providers. Coverage for each service depends on whether the provider accepts the plan’s payment terms at that point in time = no network. The beneficiary must inform the provider of enrollment in a PFFS plan to determine whether the provider will accept the plan’s payment terms each time care is needed. Since there is no network, there is no ongoing obligation for providers to accept the plan’s payment terms when care is needed. Coverage is restricted to Medicare participating providers; however, there is no access to Original Medicare as insurance when enrolled in a PFFS plan. Minimally, the plan covers medically necessary benefits received in Original Medicare. Beneficiaries enrolled in PFFS plans not offering Medicare drug coverage must join a free-standing PDP for coverage. Beneficiaries enrolled in PFFS plans offering Medicare drug coverage must accept the Part D portion of the plan.	In addition to the Part B premium, there can be premiums associated with PFFS plans. Beneficiaries who receive care from providers who will not accept the plan’s payment terms are responsible for all costs. Care is provided by any Medicare participating provider. However, providers can balance bill up to 15%. It is the responsibility of the beneficiary to: 1) determine whether the provider will accept the plan’s terms before receiving any care and 2) understand what the plan pays for each service to avoid fraudulent charges or overpayment for services received. Part D monthly premiums, deductible, and any co-pays or coinsurance for drugs.	Inpatient and outpatient care is received through Medicare participating providers who determine payment for each type of medically necessary care provided (e.g. doctor visit, hospitalization, etc). Providers may decide whether to accept the plan’s payment terms as well as whether to balance bill up to the 15% limiting charge. Appeals are filed with the plan first.