

Medicare Advantage: Questions to Ask Medicare Private-Fee-for-Service (PFFS) Plans

Medicare PFFS plans are one type of Medicare Advantage program option. Private insurance companies offer PFFS plans under contract with Medicare. Like other types of Medicare Advantage plans, PFFS plans must cover the same Medicare benefits that a person would receive under Medicare Parts A and B. Some plans may cover additional benefits, such as routine dental and vision care. PFFS plans receive a monthly payment from Medicare for each person who enrolls, though some charge an additional monthly premium. People who enroll in PFFS plans typically must continue to pay the Medicare Part B premium. The PFFS plans, not Medicare, set payment rates for doctors, hospitals and other providers. Their payments may be lower than Medicare's standard "approved amounts."

People who join a PFFS plan can go to any Medicare-approved doctor or hospital that is willing to accept the plan's payment terms and conditions. **People who join a PFFS plan must be prepared to ask all their health care providers, before receiving services, if they are willing to accept the plan's payment terms. Not all health care providers accept payments from PFFS plans.** If the provider accepts the terms, the PFFS plan pays a fee for each service. Keep in mind that doctors can decide at each visit whether or not to accept the plan's terms and whether or not to treat a patient (except for emergencies). Beginning in 2011, the PFFS plans operating in areas of the country which have at least two network-based plans must use a provider network.

A. About Access to Care in (name of PFFS): _____

1. How important is it for you to be sure that your physicians, including specialists, will provide services to you and accept insurance payments on your behalf?

In Original Medicare, you can go to any doctor who accepts new Medicare patients. The vast majority of physicians in the United States accept payments from the Original Medicare program (Medicare Part B) with no questions asked. Also, Medicare coordinated care plans like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) have networks of doctors who agree to serve anyone who is enrolled in the HMO or PPO plan. With both Original Medicare and Medicare's coordinated care plans, there is little guesswork involved in finding a doctor who accepts the payment terms.

Action step: Before enrolling in a PFFS plan, ask your doctors if they accept the PFFS plan's terms and conditions of payment. If you spend part of the year living in another locale and have doctors there, make sure to call and ask them too. **NOTE:** You must

also check with local hospitals and other places where you go for health care to see if they accept the PFFS plan's payments as well. See number two below.

Notes: _____

2. How important is it for you to be sure that hospitals, skilled nursing facilities, and home health agencies will provide you services and accept payments on your behalf?

All hospitals, skilled nursing facilities, and home health agency that receive payments from the Original Medicare program (Medicare Part A) – to the extent that they are equipped to do so – must serve Medicare patients and accept payments directly from Medicare on their behalf. With PFFS plans, you can't be sure. Health care providers, including hospitals and home health agencies, are not required to accept payments from PFFS plans. They also have the option to accept payment in one case, and not in another.

Action step: Before enrolling in a PFFS, ask your local hospital and at least one nearby Medicare-certified skilled nursing facility and home health agency if they accept the PFFS plan's terms and conditions of payment. If you spend part of the year living in another locale, make sure to call the hospital and other providers there too.

Notes: _____

3. How important is it for you to be sure that medical equipment suppliers, physical therapists, psychologists, and other health care providers will provide you services and accept payments on your behalf?

With Original Medicare, there is rarely a question about whether a medical equipment supplier or other health services provider will accept the terms of terms and conditions of payment under Medicare Part B. Similarly, with Medicare's coordinated care plans, you know what to expect because HMOs and PPOs must publish the names of suppliers and others in provider network directories. With PFFS plans, you can't be sure without asking all service providers if they are willing to accept the plan's terms of payment.

Action step: Before enrolling in a PFFS plan, ask at least one local Durable Medical Equipment supplier if they accept payments from PFFS plans. If you are currently using Medicare-covered equipment and supplies (oxygen and infusion therapy systems, for

example), call your supplier to make absolutely sure that you know if enrolling in a PFFS plan will disrupt your care.

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4. What rules does the plan have to pre-approve hospital admissions, outpatient surgery, and other costly services? Are you comfortable with these rules and the limits they may place on your access to some services?

Original Medicare pays for medically necessary services without prior approval rules. Some PFFS plans require you to call them before you receive some services and procedures, including day surgery procedures. Without prior approval, the plan may not pay for the services. Some charge a penalty for failing to notify the plan of an upcoming hospital admission.

Action step: Call the PFFS plan to ask how its prior approval process works and to tell you which medical services are subject to the procedure.

Notes: _____

B. About Out-of-Pocket Costs in (name of PFFS plan): _____

5. Are you prepared to cover the PFFS plan's copayments for inpatient hospitalization, skilled nursing facility stays, and home health care visits?

Copayments for each inpatient hospital stay vary a lot among different PFFS plans. Some plans have no copayment for hospitalizations. Others may charge several hundred dollars for each hospital stay. Some PFFS plans also only cover a portion of home health nursing and physical therapy visits.

Original Medicare's deductible for hospital stays is \$1,068 (2009) per benefit period. Most supplement insurance (Medigap) policies cover the inpatient deductible in Original Medicare. These Medigap policies **cannot** cover out-of-pocket costs in any Medicare Advantage plan, including PFFS plans. In a PFFS plan, you must be prepared to cover any and all copays on your own. Note also that there is no copay for home health care in Original Medicare. Medicare Part A covers 100 percent of the cost for medically necessary nursing and rehabilitation home visits.

Action step: Check the PFFS plan's total, annual out-of-pocket costs for one or more inpatient hospital stays. Ask how much your cost would be for three home health nursing visits or physical therapy visits.

Notes: _____

6. Which covered benefits have a fixed copayment? Which charge a coinsurance (that is, a percent of the total cost of an item or service) for services? Does the PFFS plan use a coinsurance charge to calculate your share of the cost for medical equipment, supplies, and Part B drugs, such as chemotherapy medications? Are you prepared to pay the coinsurance charges for expensive services or items?

Some PFFS plans use a coinsurance charge, typically 20 or 30 percent, for durable medical equipment (e.g., wheelchairs and oxygen equipment), medical supplies (e.g., diabetes supplies), prosthetics, and some drugs such as chemotherapy drugs and drugs used to treat anemia. The coinsurance charges for chemotherapy drugs can be very high. If chemotherapy costs \$100,000, your 20 percent share of the cost would be \$20,000 (if the plan has no annual cap on these out-of-pocket costs). Original Medicare and a Medigap insurance policy would cover the entire cost of these drugs. Medigap insurance does not work with PFFS plans to cover these coinsurance charges.

Action step: If you use medical equipment like wheelchairs, hospital beds, or oxygen tanks, ask the PFFS plan what you would owe in monthly coinsurance charges. You could also ask what your estimated out-of-pocket cost would be for expensive Part B drugs.

Notes: _____

7. Can doctors, hospitals, and other care providers bill you for the difference between the plan's payment and the provider's actual bill?

PFFS plans may allow doctors and other health care providers to bill you for part of the balance between the plan's payment rate and the provider's actual bill. The balance billing limit is fifteen percent of the plan's payment rate. If, for example, the plan's payment rate is \$100 for a service that actually costs \$150, you might owe a \$25 copayment (your share of the \$100 rate) plus fifteen percent of the \$100, or \$15, for a

total of \$40 out-of-pocket. You must keep in mind that that fifteen percent of a hospital bill can add up to a very large sum.

Original Medicare does not permit hospitals, skilled nursing facilities, home health agencies, or ambulance companies to balance bill. It does, however, permit physicians to collect up to 15 percent of Medicare's approved amount on the balance of a doctor's bill. Physicians who collect the higher charge are said not to "accept assignment." In recent years, physicians in Original Medicare accepted assignment, meaning they did not charge an additional 15 percent above Medicare's approved amount, 99 percent of the time. They took Medicare's approved amount as payment-in-full. Medicare publishes a list of physicians who always accept assignment in Original Medicare. They are called "Participating Physicians." Go to www.medicare.gov and click on "Find a Doctor." People with Original Medicare and a Medigap policy have no out-of-pocket costs or balance billing when doctors accept assignment. Those without a Medigap policy pay the 20 percent co-insurance under Original Medicare.

Action step: Ask the PFFS plan about which health care providers can "balance bill." Does the list include hospitals, skilled nursing facilities, medical equipment suppliers, and ambulance companies?

Notes: _____

8. Does the PFFS plan have a cap on annual out-of-pocket spending? Does it have separate caps for medical and prescription drug coverage? Are you prepared financially to cover out-of-pocket costs up to the cap (or beyond)?

Most PFFS plans expect you to pay an out-of-pocket amount for services such as inpatient hospital stays, doctor visits, and outpatient care. In some medical situations, you could owe many thousands of dollars in combined copayment and coinsurance charges. Annual limits place a cap on your out-of-pocket spending. After you reach the limit, the plan pays 100 percent of the cost for your ongoing care. A reasonable out-of-pocket limit is about \$2,500 to \$3,000. This is the amount you would spend for the year. Some PFFS plans have annual spending caps of \$4,000 or more, and some have no caps at all. Others have separate caps on total inpatient hospital copayments.

Action step: Ask the PFFS plan to explain which services apply to the annual limit on out-of-pocket spending. Do balance billing amounts (see number seven above) count toward the cap?

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9. Does the PFFS plan offer prescription drug coverage through Medicare Part D?

PFFS plans are not required to offer prescription drug coverage under Medicare Part D. Some PFFS plans offer Part D drug coverage. Others do not. If a PFFS plan does not cover prescription drugs, you can enroll in a stand-alone prescription drug plan sponsored by a different insurance plan. Note that co-payments for prescription drugs usually do not count toward a PFFS plan's annual cap on out-of-pocket costs for other medical services and supplies (see number eight above).

Action step: Ask if the PFFS plan includes Part D prescription drug coverage.

Notes: _____

Remember: You have the right to have your questions answered. You can take home a PFFS plan's application and other information materials and think about it. Before enrolling in any Medicare Advantage product, including PFFS plans, weigh your health coverage options and costs carefully. Talk to people you trust, including counselors at your state's SHIP program, who have nothing to gain from your enrollment decision. Because all Medicare Advantage products change how you receive your health care benefits through Medicare, do not rush to a decision or sign anything under pressure.