

## **Medicare Advantage: Questions to Ask Medicare Preferred Provider Organization (PPO)**

Medicare PPOs are one of the Medicare Advantage program's coordinated care plans. They agree to provide all the Medicare-covered benefits a person would receive under Medicare Parts A and B, and sometimes cover additional benefits. PPOs receive a monthly payment from Medicare for each person who enrolls. Some charge enrollees an additional monthly premium. People who enroll in PPOs typically must continue to pay the Medicare Part B premium.

People who join PPOs can save money by receiving services from doctors, hospitals, and others who belong to the PPO's "preferred provider" network. PPO plan members can go to other health care providers who do not belong to the PPO's provider network, but it will usually cost more. PPO plans work like Health Maintenance Organizations (HMOs) in many ways, with one big difference. PPOs allow you to go to out-of-network doctors and specialists without needing referrals or prior authorization.

The Medicare Advantage program has two kinds of PPOs: regional PPOs and local PPOs. Regional PPOs may cover a statewide or multi-state region. They have network providers throughout the region. Local PPOs cover a county or multi-county area, so their provider networks are usually smaller. Another difference between the two kinds of PPOs is that regional PPOs must have an annual limit – or cap – on out-of-pocket spending. Local PPOs may have a spending cap, but it is not required for them.

While Medicare PPOs may work well for many people, they are not for everyone. It is important to understand what the different costs for in-network and out-of-network services mean for your access to health care and budget before you enroll. Take some time to get answers to the questions below. Use the space provided to jot down the names of plan contacts and the answers they give.

**A. About Access to Care in (name of PPO):** \_\_\_\_\_

### **1. Are your doctors, including specialists, and hospitals part of the PPO's provider network?**

To keep your out-of-pocket costs as low, you must use the health care providers in the PPO's provider network. Copayments to see an in-network doctor may be as low as \$10 per visit. But if your doctor or hospital does not belong to the provider network, you could owe an annual deductible plus as much as 30 percent of the bill. While PPOs give you the flexibility to see primary care doctors and specialists that are not on the PPO's list of preferred providers, you must be prepared to pay more when you do so. Note

that some PPOs will charge you less for out-of-network care when you inform the plan before you go to the doctor or hospital.

**Action step:** Call your doctors to ask if they belong to the PPO's preferred provider network. Call the PPO to ask about its rules for prior authorization for out-of-network care.

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## **2. Does the PPO have network hospitals, diagnostic centers, pharmacies, and other facilities that are conveniently located for you?**

Medicare PPOs do not need to have all the hospitals in your community in their provider networks. If you go to a hospital that is out-of-network, you will pay a lot more than you would in a network hospital. In a network hospital, your out-of-pocket costs for a five-day inpatient stay could be in the \$150 to \$600 range and may include a deductible. At an out-of-network hospital, you typically would owe 30 percent of the bill with the potential for many thousands of dollars in costs. Note that Original Medicare will pay for care at nearly all hospitals in the U.S., with a deductible of \$1,068 per benefit period (2009). Most Medicare Supplement (Medigap) insurance policies cover the hospital deductible in Original Medicare, but they cannot help with the out-of-pocket costs in a PPO.

**Action step:** Ask the PPO if the hospital you want to use is in its provider network.

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## **3. How often do you travel outside of the HMO's service area? How long are your absences from the area?**

To enroll in a Medicare PPO, you must live in the plan's service area for most of the year. The service area for some PPOs covers multi-state regions. Others cover just one or more counties. Note that doctors and hospitals outside of the PPO's service area typically do not belong to its provider network. In non-emergency or non-urgent situations you generally will owe 30 percent of the total bill for out-of-network doctor and hospital care. It is important for people who live several months each year away from home to carefully weigh the potential impact of out-of-network costs on their health care budgets.

**Action step:** Ask the PPO about its rules, procedures, and costs for covering care outside of its service area.

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**B. About Out-of-Pocket Costs in (name of PPO):** \_\_\_\_\_

**4. Does the PPO have a cap on annual out-of-pocket spending? Does it have separate caps for in-network and out-of-network services? Are you prepared financially to cover out-of-pocket costs up to the cap (or beyond)?**

A reasonable out-of-pocket limit is about \$2,500 to \$3,000. This is the amount you would spend for the year. Note that all regional Medicare PPOs must have caps on your annual out-of-pocket spending. Local PPOs are not required to have annual spending caps, though many do. Note that PPOs may have separate spending caps for in-network and out-of-network services. In some medical situations, you could owe several thousand dollars in combined copayment and coinsurance charges especially if the spending caps do not apply to the services that you require.

**Action step:** Ask the PPO about which services apply to the annual limit or cap.

**Notes:** \_\_\_\_\_  
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The plan’s annual cap for in-network services is: \_\_\_\_\_

The plan’s annual cap for out-of-network services is: \_\_\_\_\_

**5. Are you prepared to cover the PPO’s copayments for hospital stays?**

Copayments of \$150 to \$200 per day for the first five days – or more – of a hospital stay are common. Ten days in a hospital could cost in excess of \$1,500. Original Medicare’s deductible for hospital stays is \$1,068 per benefit period (2009). Most supplement insurance policies cover the cost in Original Medicare, but not for a PPO.

**Action step:** Check the PPO’s total out-of-pocket cost for an inpatient hospital stay.

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**6. What are the copayments for Skilled Nursing Facility (SNF) care and Home Health care? Do the costs count toward the annual out-of-pocket limit?**

Original Medicare pays the whole cost of the first 20 days of skilled nursing facility care. It also pays the whole cost of medically necessary home health nursing and therapy visits without a set limit on the number of visits. There is no 20 percent coinsurance charge. PPOs, however, may have copayments for these same services.

**Action step:** Check the PPO's co-payments for SNF and Home Health care.

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**7. What are the PPO's copayments for in-network and out-of-network outpatient surgery and other outpatient medical procedures? Are you prepared to cover the out-of-pocket costs for multiple outpatient visits, physical therapy treatments, and ambulance trips?**

Many surgical, medical, and rehabilitation procedures routinely occur in an outpatient setting. Copayments for each outpatient service are \$100 or more at some PPOs. The copayments for a series of outpatient visits, as with physical therapy after a stroke, can quickly add up to thousands of dollars. With out-of-network outpatient services, you typically would owe 30 percent of the total bill.

**Action step:** Ask the PPO about copayments for outpatient hospital services, including day surgery and rehabilitation. Ask about the services that do not count toward the annual out-of-pocket spending limit.

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**8. Which covered benefits have a fixed copayment? Which have coinsurance charges, that is, a percent of the total cost of an item or service? Does the PPO use a coinsurance to calculate your share of the cost for medical equipment, supplies, and**

**Part B drugs, such as chemotherapy medications? Are you prepared to cover the coinsurance charges for expensive services or items?**

Most PPOs apply a coinsurance charge of 30 percent to out-of-network services. Many also apply a coinsurance charge, often 20 percent, to durable medical equipment (such as wheelchairs and oxygen equipment), medical supplies, prosthetics, and some Part B drugs. These include chemotherapy and other drugs involved in cancer treatment. The coinsurance charges for chemotherapy drugs can be very high. With chemotherapy costing as much as \$100,000, your 20 percent share of the cost would be \$20,000 (if the plan has no annual cap on out-of-pocket costs). Original Medicare also has a 20 percent coinsurance charge for medical equipment, supplies, and Part B drugs. Medicare Supplement (Medigap) insurance covers the 20 percent coinsurance in Original Medicare but not in a Medicare PPO.

**Action step:** If you use medical equipment like wheelchairs, hospital beds, or oxygen tanks, ask the PPO what you would owe in monthly coinsurance charges. You should also ask what your cost would be for specific Part B drugs you have used.

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

PPO plans are not required to offer prescription drug coverage under Medicare Part D. If your PPO plan does not cover prescription drugs, you cannot enroll in a stand-alone prescription drug plan sponsored by a different insurance plan.

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

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**Remember:** You have the right to have your questions answered. You can take home a PPO plan's application and other information materials and think about it. Before enrolling in any Medicare Advantage product, including PPO 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.