

RELATIONSHIP TO MEDICARE ADVANTAGE

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- MA Plans and Part D

INTRODUCTION

Medicare beneficiaries have the option of receiving their Medicare benefits through the Original Medicare program, also known as fee-for-service Medicare, or through a Medicare Advantage (MA) plan, sometimes called a Medicare Health Plan. Many MA plans offer added benefits, such as routine eye care, that are unavailable in Original Medicare. The monthly premiums of most Medicare Advantage plans can be much lower than those of Medicare Supplement (Medigap) policies. For many people, these features make MA plans an attractive alternative to coverage through Original Medicare and a Medigap policy.

Note: Federal law does not allow Medicare Supplement (Medigap) policies to cover the copayments found in MA plans. People who enroll in MA plans should be prepared to cover these copayments out-of-pocket.

Generally, Medicare beneficiaries may enroll in an MA plan under the following conditions:

- They must have both Medicare Part A and Part B.
- They must live in the MA plan's service area.
- They cannot have end-stage renal disease (ESRD) at the time they enroll, except if enrolling in certain Special Needs Plans (SNPs).
- If enrolling in a Special Needs Plan (SNP), they must meet the eligibility criteria for the SNP.

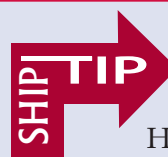
Note: Special Needs Plans (SNPs) are MA plans which are designed for specific subsets of the Medicare population. SNPs may limit enrollment to one of three Medicare beneficiary populations – institutionalized beneficiaries, full dual-eligible Medicare beneficiaries (beneficiaries who have both Medicare and Medicaid), and beneficiaries diagnosed with certain chronic and disabling disease conditions.

TYPES OF MA PLANS

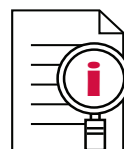
MA plans include a number of plan types. The most prevalent nationally are Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Special Needs Plans (SNPs), and Private Fee-for-Service (PFFS) plans. The common thread among them is that they operate under Medicare Part C and receive a set payment from CMS to deliver Medicare-covered services for each beneficiary they enroll. Other plans include Cost plans, Provider Sponsored Organizations (PSOs), Medicare Medical Savings Accounts (MSAs), and PACE plans.

Some types of Medicare Advantage plans, including HMOs, PPOs, Cost plans, SNPs, and PSOs, are managed care or coordinated care systems. Plans that coordinate the care of enrollees encourage prevention, follow-up on routine and recommended services, and sometimes substitute less expensive alternatives for some procedures. MA plans have different rules for different procedures, and enrollees must follow those rules for the plan to pay for the medical service or product. Also, some MA plans have a network of participating providers, including physicians and hospitals, through which the enrollees typically must get their routine, non-emergency care.

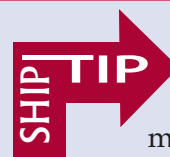
Other plans are not coordinated care plans. The most common of these non-coordinated care plans are PFFS plans and MSAs. In contrast to coordinated care plans, PFFS plans and MSA plans operate on a fee-for-service basis. This means that enrollees go to a doctor or hospital to receive services, and the plan pays for the care. Like Original Medicare (another fee-for-service system), these plans have coverage criteria and will not pay for services received unless they are considered medically necessary. For example, a PFFS plan will not pay for elective surgery or for cosmetic procedures. To contrast these plans with the coordinated care plans, the coordinated care plans might pay for a surgery only if drug therapy fails.



Enrolling in any Health Plan, such as an MA-PD, PFFS, HMO, or PPO, may automatically disenroll a beneficiary from other existing coverage that he may have. CMS has taken steps to prevent this circumstance from occurring.



For more information on PFFS plans and the 2011 changes in plan network requirements, see the "Types of Plans" section of HAP's SHIP Resource Guide: Medicare Advantage, available online at <http://www.hapnetwork.org/medicare-advantage/ship-resource-guide/types-of-plans.pdf>.



In terms of out-of-pocket costs, it's a good idea to keep in mind that beneficiaries in Original Medicare can purchase a separate policy (Medigap) to help pay for cost-sharing, but those in MA plans must be prepared to pay out-of-pocket for their entire cost-sharing amount.

Many managed care plans require a physician's prior approval as a condition of payment for certain services, including visits to specialists and high-cost diagnostic procedures. Furthermore, cost-sharing requirements for MA plans often differ significantly from those in Original Medicare. For example, Original Medicare fully covers the first 20 days in a skilled nursing facility, but MA plans can charge a copayment or coinsurance for those same days.

MA-PDs are required to pay for emergency or urgent care provided outside of their network of providers. All Part D plans must provide adequate access for enrollees at pharmacies outside of the plan's network in instances where enrollees could not reasonably be expected to receive coverage within the network. Common examples of such situations include extended travel outside of the service area, emergency room situations that include the administration of Part D drugs, and during federal disasters. Similarly, MA plans (including MA-PDs) are required to provide coverage for all emergency and urgent care, regardless of network and prior authorization rules.

Despite these differences, Medicare rules require MA plans to deliver all the benefits and services that beneficiaries would have in Original Medicare. But the MMA does not require all Medicare Advantage plans to offer Part D prescription drug coverage.

Certain MA plans have rules about who can enroll (e.g., SNPs) or rules about who cannot enroll (e.g., MSAs). For example, Special Needs Plans for people with institutional care (Institutional SNPs or I-SNPs) are designed to serve only the population of Medicare beneficiaries living in long-term care facilities.

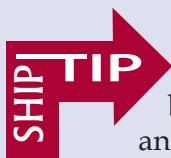
CMS requires coverage for emergency care regardless of the final diagnosis. For example, an enrollee believes he is having a heart attack and goes to the closest emergency room, which happens not to be in his plan's network. After several tests the physicians diagnose the enrollee with a panic attack. The enrollee's MA plan must provide coverage for the visit, despite the eventual diagnosis. MA plans must use the "prudent layperson" standard. That is, if a prudent layperson would believe the situation requires emergency or urgent care, then the MA plan must provide coverage.

MA PLANS AND PART D

Generally, Medicare beneficiaries who want drug coverage and the benefits of a Medicare Advantage plan must select an MA plan that offers Part D prescription drug coverage (MA-PD). This rule is absolute for all coordinated care plans (i.e., HMOs, Cost plans, PPOs, PSOs, and SNPs). Those beneficiaries enrolled in coordinated care plans who want Part D coverage must enroll in coordinated care plans that have a Part D component – an MA-PD plan. This means that enrollees in coordinated care plans without Part D coverage – MA-only

plans – will not have access to drug coverage through Medicare. Furthermore, Special Needs Plans (SNPs) must provide Part D coverage. Thus, all SNPs are MA-PDs, and enrollees have access to Medicare drug coverage through their SNPs.

An exception applies to beneficiaries who are enrolled in certain types of MA plans that do not provide drug coverage, including some PFFS plans and all Medical Savings Account (MSA) plans. Private Fee-for-Service plans may or may not have Part D coverage. For those PFFS plans that are MA-PDs, enrollees must take the Part D coverage that comes with the plan. For those PFFS plans that do not offer drug coverage, enrollees may also enroll in stand-alone Prescription Drug Plans (PDPs) to receive Part D coverage. Additionally, MSA plans are not permitted to offer drug coverage, so enrollees in these plans also may enroll in stand-alone PDP plans.



It is important to remember the differences between Original Medicare and Medicare Advantage when working on the Internet with clients. The Medicare Web site has two different online search engines for Medicare plans. People can search for Medicare drug plans using the Plan Finder at <http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/SearchOptions.asp>. The Plan Finder allows users to limit their searches to PDPs, MA-PDs, or both. While the results of these searches are separated by category, it is

critical to keep in mind the differences between Original Medicare and Medicare Advantage as you assist clients in the process of comparing and selecting a Medicare drug plan or health plan with drug coverage. The Medicare Web site also has a second search engine, *Medicare Options Compare*, at <http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp>, which allows users to search for Medigap policies or to compare MA and Original Medicare choices in their area.

Please refer to HAP's SHIP Resource Guide: Medicare Advantage, available online at <http://www.hapnetwork.org/medicare-advantage/ship-resource-guide/medicare-advantage.html>, for more in-depth information about the Medicare Advantage (MA) program.