MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Objectives

Below are the topics covered in Module 5, Medicare Advantage (MA) Health Plan Options.

This module will help to ensure that HIICAP counselors understand all the options available to people with Medicare and give counselors the tools to assist their clients in making wise independent choices.

At the end of this module are the Study Guide Test and Answer Key.

What Medicare options do I have in New York State?

- Original Medicare
- Original Medicare with a Medicare Supplement Insurance policy (Medigap)
- Medicare Advantage Plans (MAPs)
- Special Needs Plans (SNPs)
- Certain individuals who are enrolled in both Medicare and Medicaid **and** who need Long Term Care Services may have other choices. These options will be discussed briefly later in this module. Please refer to Module 17, HIICAP Notebook: *Medicaid* for a full description.
    - https://aging.ny.gov/hiicap-notebook

What is required to be eligible for a Medicare Advantage health plan?

- Must have Medicare Part A **and** Medicare Part B
- Must live within the service area where the plan accepts enrollees
- Since 2021, beneficiaries with End-Stage Renal Disease (ESRD) at time of enrollment **are** eligible for Medicare Advantage.

How does someone choose an option?

- By comparing different Medicare Advantage plans in their area. When choosing an option, one must also compare having an MA plan vs. the flexibility of remaining with Original Medicare with or without a Medicare supplement plan and/or employer (or retiree) insurance.
- By choosing a primary care physician (specific to HMO plans).

Medicare Advantage (MA) Star Ratings

- The star ratings system began in 2007 as a way for the Centers for Medicare & Medicaid Services (CMS) and Medicare beneficiaries to assess MA health plans.
- Medicare gives star ratings for health plan quality and performance. The top rating is five stars. Plans with the ratings of four or five stars get extra money from the government to spend on medical benefits.
- The measures target a broad array of beneficiary experience areas including customer satisfaction and the quality of care the plan delivers.

Why join a Medicare Advantage (MA) plan?

- Predictable co-payments for doctor visits and other outpatient medical services.
- MA plans may offer benefits not available in Original Medicare, such as dental care, hearing aids, or eyeglasses.
- Maximum Out-of-Pocket amounts (MOOP).

- All MA plans must have yearly MOOP amounts for all Part A and B covered services, not to exceed $7,550 (HMO) or $11,300 (PPO), including $7,550 in-network. This is a key benefit and protection for the beneficiary. MOOP will be discussed in further detail later in this module.

What should be considered before joining a MA plan?

- What is the plan premium and what are other out-of-pocket costs?
- What providers are available to members?
  - Does the plan require a member to use only a network of providers?
  - If the plan requires beneficiaries to use a network, can they only see network providers or are they allowed to also use out-of-network providers (possibly at a higher cost-sharing amount)?
  - If the beneficiary already has a primary care physician and/or already sees specialist physicians, are those providers in the plan's network?
- Can services be obtained outside the network?
  - Is the plan an HMO, HMO-POS, PPO or PFFS? (These terms and plans will be defined several pages down in this module).
  - How much will the plan pay for out-of-network care in an emergency or when urgent care is needed?
  - Does the plan offer benefits for when members are traveling away from home?
- Does the MA plan include prescription drug coverage (Part D)?
  - Are the beneficiary's drugs on the formulary? What are the expected prescription drug costs?
    - If the beneficiary uses insulin, does the plan participate in the Part D Senior Savings Model, which is designed to offer insulin at an affordable and predictable cost where a one-month supply of a broad set of plan-formulary insulins costs no more than $35 each?
- Are additional services (supplemental benefits) offered and what are they?
- What are the restrictions on when a member can change/leave their Medicare Advantage plan?
- Is the plan's star rating 3.5 or higher?
- Is the beneficiary entitled to other coverage, such as through the Department of Veterans Affairs (VA) or TRICARE (health benefits for military families and retirees)?

MORE MEDICARE HEALTH PLAN CHOICES

There are a few different ways to get Medicare health care coverage. No matter which option your client chooses, they are still in the Medicare Program. All Medicare health plans must provide all Medicare-covered services. However, not all Medicare health plan choices may be available in your client's area. The Medicare & You Handbook lists the Medicare health plan choices available at the time the handbook is published. For the most current list of Medicare health plan choices look on the internet at www.medicare.gov/plan-compare. A local library or senior center may have computers your client can use to get information. Beneficiaries can also get current plan information by calling 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048, 24 hours/day, 7 days/week.

ELIGIBILITY

To be eligible for one of the Medicare Advantage health plan choices:

- **A person with Medicare must have Part A (Hospital Insurance) and Part B (Medical Insurance).** If your client is not sure if they have Part A and Part B, the client can call the

Social Security Administration at 1-800-772-1213 or call 1-800-MEDICARE (1-800-633-4227). They can also create an account at https://www.ssa.gov/myaccount/.

- **A person with Medicare must live in the service area of a health plan.** The service area is the geographic area where the plan accepts enrollees. For plans that require a person with Medicare to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll a member if they move out of the plan's service area. If your client is disenrolled, they are automatically covered under Original Medicare. A person with Medicare who moves to a new area may be able to join a Medicare health plan in their new area if one is available. A person who is incarcerated does not live in a plan service area.

Consumer Tip: If your client is happy with the way they get health care now, they don't have to do anything. If they do nothing, they will continue to receive their Medicare health care in the same way they always have.

- **Since 2021, beneficiaries with End-Stage Renal Disease (ESRD) have been eligible to enroll in a Medicare Advantage plan.** ESRD is permanent kidney failure that requires dialysis or a transplant.

MEDICARE OPTIONS

- **Original Medicare**
- **Original Medicare with a Medicare Supplement/Medigap Policy**
- **Medicare Advantage (MA) Plans:**
  - Health Maintenance Organization (HMO)
  - HMO with Point-of-Service option (HMO-POS)
  - Preferred Provider Organization (PPO)
  - Private Fee-for-Service (PFFS)
  - Medicare Medical Savings Account (MSA)
  - Medicare Special Needs Plan (SNP)
- To learn about other options for individuals that are enrolled in both Medicare and Medicaid **and** who also need Long Term Care Services, see Module 17, HIICAP Notebook; *Medicaid*. https://aging.ny.gov/hiicap-notebook

Note: Currently, all of the Medicare Advantage plan options are available in New York State, but not all plan types are available in each county.

Original Medicare

Original Medicare is the traditional system, run by the federal government, which covers Part A and Part B services. Medicare pays its share of the bill and the person with Medicare is responsible for the Medicare cost-sharing amounts.

Cost: The monthly Part B premium, Part A and Part B deductibles, and the cost sharing. *(*Refer to Module 3, *Medicare Part A Hospital Insurance* and Module 4, *Medicare Part B Medical Insurance* of the HIICAP Notebook for more information.) The need for, and separate cost of, a prescription drug plan (PDP) needs to be considered as well. (Refer to Module 6, *Medicare Prescription Drug Coverage (Part D)* for more information.) https://aging.ny.gov/hiicap-notebook

Providers: Any medical provider or hospital that accepts Medicare.

Extra Benefits: One receives all the Medicare Part A and Part B covered services, but no extra benefits.

Original Medicare with a Medicare Supplement/Medigap Policy

Original Medicare is the traditional system that covers Part A and Part B services. Medicare pays its share of the bill and the person with Medicare is responsible for the Medicare cost-sharing amounts.

A person with Medicare may purchase one of the standard Medicare Supplement (Medigap) plans available in New York State. These policies pay for many of the out-of-pocket costs under Original Medicare.

Cost: The monthly Part B premium and an additional monthly premium for the Medicare Supplement/Medigap policy. All policies cover Medicare's hospital coinsurance amounts and most pay for Medicare's Part A deductible. The premium varies by region and insurer. New York State is a community-rated state; therefore, everyone in the same region of the state pays the same premium for the exact same policy sold by the same insurer. Your client may also pay a co-payment per visit or service depending on the Medicare supplement plan. The need for, and separate cost of, a prescription drug plan (PDP) needs to be considered as well.

Providers: Any medical provider or hospital that accepts Medicare.

Extra Benefits: The person with Medicare receives all Medicare Part A and Part B covered services. Medigap plans generally do not provide any extra benefits. However, most Medicare Supplement/Medigap Policies also cover emergency care received outside of the United States, which Original Medicare does not.

(*Refer to Module 7, HIICAP Notebook; *Medicare Supplement Insurance/Medigap*.)
https://aging.ny.gov/hiicap-notebook

Medicare Advantage (MA) Plans

A Medicare Advantage plan (like an HMO or PPO) is another way to get Medicare coverage. Medicare-approved private companies that must follow rules set by Medicare offer Medicare Advantage plans, sometimes called "Part C" or "MA Plans." If a beneficiary joins a Medicare Advantage plan, they'll still have Medicare, but they'll get their Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage plan, not Original Medicare. They'll generally get their services from a plan's network of providers. Remember, in most cases, a Medicare beneficiary must use the card from their Medicare Advantage Plan to get Medicare-covered services. Beneficiaries should keep their Medicare card in a safe place because they'll need it if they ever switch back to Original Medicare.

Medicare Advantage Plans include **Health Maintenance Organization (HMO), Health Maintenance Organization with Point of Service Option (HMO-POS), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), Medicare Medical Savings Account (MSA), Medicare Special Needs Plan (SNP).**

Cost*:* The monthly Part B premium. Some plans charge an extra monthly premium. Your client may also pay a co-payment per visit or service. With an HMO, your client will be responsible for all charges if they go out-of-network except for emergency services, urgent care, and out-of-area dialysis.

Caution: Medicare Supplement/Medigap Policies do NOT work with Medicare Advantage Plans.

Providers: The choice of doctors and hospitals varies by the type of Medicare Advantage plan. HMO plans are typically more restrictive; however, under a PPO plan, a person with Medicare may use doctors and hospitals outside of the plan's network for an additional cost.

Extra Benefits*:* The person with Medicare receives all Medicare Part A and Part B covered services. Most Medicare Advantage plans offer additional benefits not covered under Original Medicare such as dental care, eyeglasses, and hearing aids.

Caution: For hospital admissions, Medicare Advantage plan members may be subject to substantial cost sharing, usually in the form of a daily co-payment for a limited number of days. Make sure to check the plan details regarding the hospital benefit.

Health Maintenance Organization (HMO)

An **HMO** should offer comprehensive health insurance, with fixed costs and little or no paperwork for claims submission. However, other considerations need to be mentioned. The plan may require members to get referrals from a primary care physician in order to see specialists in their network. They may also change coverage and/or premiums annually. There may be additional costs such as hospital and skilled nursing facility co-payments. There may be prior authorization (approval) requirements for certain services.

Also, providers can choose to no longer participate with an HMO plan during the year. Even participating providers may decide at any point that they are not accepting new patients under the Medicare HMO plan. Generally, members are required to use *only* health care providers in the HMO plan's network.

IMPORTANT: If a member wants to use a particular primary care doctor, check to see if he or she is accepting new patients in the plan. The doctor may be participating in the HMO, but not accepting new patients in that plan. If the beneficiary is an existing patient of the doctor in the HMO, the doctor may be able to continue seeing the patient even if he or she is not accepting new plan patients, but this question should be asked before joining the plan.

HMO with Point of Service Option (HMO-POS)

An HMO with a Point of Service option, or **HMO-POS**, is an HMO where a member may receive some services outside of the plan's network of providers.

Usually, a member will pay a higher amount if they use non-network providers. There may also be limits on the types of services covered outside the plan's network. Prior authorization may be required. Check with the individual plan for details on the out-of-network coverage.

Preferred Provider Organization (PPO)

A **PPO** has a network of preferred providers (hospitals, physicians and other providers) who provide all of the basic Medicare benefits, like Medicare HMOs. Unlike HMOs, PPOs provide some coverage for services provided outside of their network. Cost-sharing amounts will usually be lower when beneficiaries use network providers than when they use out-of-network providers. A PPO must have a sufficient network of providers so that enrollees can get all services within the plan. Also, with a PPO, a member does not have to get a referral to see a specialist. Premiums are usually more than HMO premiums, but less than premiums for Medicare Supplement insurance.

Medicare Advantage plans, including PPOs, must offer all of Medicare's required benefits. They may also offer additional benefits, such as dental care, eyeglasses or hearing aids.

Note: Some companies may offer a Regional PPO (RPPO) that serves the entire state of New York, rather than select counties. Currently, United Healthcare is the only company offering a RPPO in New York State. Other companies may offer PPO plans in only certain counties of the state.

Caution: People with Medicare who are enrolled in an HMO, HMO-POS, or PPO Medicare Advantage plan who want Part D drug coverage must get it through that Medicare Advantage plan. They cannot purchase a separate stand-alone Part D plan (PDP). Doing so would cause them to be disenrolled from their Medicare Advantage plan. There may be an exception to this rule for some employer-sponsored health plans.

Private Fee-for-Service Plan (PFFS)

Under a PFFS plan, a person with Medicare may go to any Medicare-participating medical provider or any hospital, as long as the provider or hospital accepts the plan's payment terms. PFFS plans also have networks of providers and are very similar to PPO plans. No referrals are necessary. Costs may include a monthly premium and an amount per visit or service.

Like other Medicare Advantage plans, the person with Medicare may receive extra benefits that Original Medicare doesn't cover.

Caution: PFFS plan members should check to make sure their doctors, hospitals, and other providers will agree to treat them under the plan and that they will accept the PFFS plan's payment terms.

Note: Prescription drug coverage (Part D) may be included in the PFFS plan. But if the PFFS plan does not include drug coverage, a person with Medicare can also enroll in a separate stand-alone Medicare Prescription Drug Plan (PDP).

Medicare Medical Savings Account (MSA)

Medicare MSA plans combine a high deductible Medicare Advantage plan with a medical savings account. The plan deposits an amount annually into an account that can be used for medical expenses. Any unused portion can be carried over to the next year. Once the high deductible is met, the plan pays 100% of covered expenses. Preventive services may not be subject to the deductible and coinsurance. MSA plans do not have a provider network. MSA plan members can use any Medicare provider.

The medical savings account can also be used to pay for non-Medicare covered medical expenses such as for dental care, vision or hearing aids, but only payments made for Medicare (Part A and Part B) covered expenses will be credited toward the plan deductible.

Note: If a person with Medicare is in a Medicare MSA plan, they cannot leave their plan (disenroll) during the January 1 – March 31 open enrollment period. If they choose a Medicare MSA plan for the first time during the Annual Coordinated Election Period and then change their mind, they can cancel their enrollment by December 15 of the same year. They still only have until December 7 to join another health or drug plan. After December 7 and up to December 15, the beneficiary can only return to Original Medicare.

https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/joining-a-medical-savings-account-plan

Note: Prescription drug coverage (Part D) is not included in an MSA plan. A person with Medicare in an MSA plan must enroll in a separate stand-alone Medicare prescription drug plan in order to have drug coverage under Medicare.

Medicare Special Needs Plan (SNP)

A Medicare SNP is a type of Medicare Advantage plan that is only available for certain Medicare beneficiaries, such as those with both Medicare and Medicaid (which may include those with QMB only without Medicaid), institutionalized beneficiaries or those with certain chronic conditions. SNPs may offer more focused and specialized health care as well as better coordination of care for these beneficiaries than other types of Medicare Advantage plans. All SNPs include Part D drug coverage.

Program of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare program for older adults and people over age 55 living with disabilities. This program provides community-based care and services to people who would otherwise need nursing home-level care. PACE provides all the care and services covered by Medicare and Medicaid, as well as additional care and services not covered by either program. Beneficiaries with either Medicare or Medicaid or both can join a PACE plan. They must live in the service area of a PACE organization.

Note: PACE plans are not considered Medicare Advantage Plans

Counseling Beneficiaries about MA Plans

HIICAP counselors cannot endorse a particular Medicare Advantage (MA) plan, but can help clients get information needed to decide if an MA plan meets their needs.

Detailed information on Medicare Advantage options is available at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048, 24 hours a day/7 days a week.

Fully Integrated Duals Advantage (FIDA) Plan FIDA plans were phased out at the end of 2019. For more information on other options for managed long-term care see Module 17, HIICAP Notebook; *Medicaid*. https://aging.ny.gov/hiicap-notebook

MEDICARE ADVANTAGE (MA) ENROLLMENT PERIODS

Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to **both** Medicare Part A and Part B and ends on the later of:

- The last day of the individual's Part B initial enrollment period or
- The last day of the month preceding the individual's entitlement to both Part A and Part B

Annual Coordinated Election Period (AEP)

Eligible Medicare beneficiaries can enroll in a Medicare Advantage plan or switch their plan choice (either Medicare Advantage or Prescription Drug Plan) during the Annual Coordinated Election Period, which runs every year from October 15 to December 7. Any election made during this period will be effective the following January 1.

Medicare Advantage Open Enrollment Period (OEP)

During the OEP (January 1 – March 31), beneficiaries enrolled in a Medicare Advantage plan (with or without prescription drug coverage) have one opportunity to switch to Original Medicare or another Medicare Advantage plan. The change is effective the first day of the month following the month of the enrollment change (February 1, March 1, or April 1). If they switch to Original Medicare or to a Medicare Advantage plan without prescription drug coverage, beneficiaries then have a coordinated special enrollment period to join a Medicare Part D prescription drug plan. Beneficiaries can sign up for a Part D stand-alone prescription drug plan even if their former MA plan did not include Part D drug coverage.

A similar provision applies to individuals who are newly entitled to both Medicare Part A and Part B on a date other than January 1 and who are enrolled in a Medicare Advantage plan. These beneficiaries may change their Medicare Advantage plan once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the third month of the entitlement. They are entitled to the same coordinated special enrollment period for Part D prescription drug coverage as described above for the OEP.

Caution: Unlike other types of MA plans, beneficiaries enrolled in an MSA plan cannot use the Open Enrollment Period to disenroll from the plan and return to Original Medicare.

Special Enrollment Period (SEP)

A Special Enrollment Period (SEP) is an exception where people with Medicare may be able to enroll, disenroll or switch their Medicare Advantage plan outside of the other enrollment periods. An SEP may be available for a number of different reasons, including for a change in residence, loss of an employer/retiree plan or for people with Medicare who enroll in a MA plan when first eligible for Medicare at age 65.

Note: An SEP exists for individuals affected by a weather-related emergency or major disaster who had another enrollment period during this time but were unable to and did not make an election as a result of the emergency or major disaster. This includes both enrollment and disenrollment elections. For example, this SEP was available nationwide due to the COVID-19 pandemic from March 13, 2020 to July 13, 2020. See https://www.cms.gov/files/document/special-enrollment-period-sep-individuals-affected-fema-declared-weather-related-or-other-major.pdf

5-star Special Enrollment Period

A beneficiary can switch to a Medicare Advantage Plan or Medicare Advantage Plan with prescription drug coverage that has an overall 5-star rating from December 8 to November 30. Beneficiaries can only use this special enrollment period once during this time frame.

SEP65

People with Medicare who enroll in an MA plan (other than an MSA plan) during the Initial Enrollment Period (IEP) for Part B surrounding their 65th birthday have a Special Enrollment

Period (SEP). This "SEP65" allows the individual to disenroll from this MA plan and elect Original Medicare any time during the 12-month period that begins on the effective date of coverage in the MA plan.

IMPORTANT: The SEP65 can only be used to return to Original Medicare. Unless the beneficiary qualifies for another Special Enrollment Period (SEP), switching to a different MA plan can only be done during the Annual Coordinated Election Period (AEP) (October 15 – December 7) or the Medicare Open Enrollment Period (OEP) (January 1 – March 31). Beneficiaries can also return to Original Medicare during the OEP. (The OEP does not apply to MSA plans as previously noted.)

Caution: If a beneficiary's Medicare Advantage Plan includes prescription drug coverage and the beneficiary joins a stand-alone Medicare Prescription Drug Plan, the beneficiary will be disenrolled from his or her Medicare Advantage Plan and returned to Original Medicare.

Note: Beneficiaries simply not paying their MA plan premiums does not guarantee that the beneficiaries will be disenrolled from their MA plan and returned to Original Medicare.

What if a person with Medicare no longer wants to be in an MA plan?

During the periods in which a person can disenroll from a Medicare Advantage plan, as described above, a beneficiary who wants to disenroll can send a signed request to the plan, but is not required to do so. The beneficiary could also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week, to disenroll when eligible.

When a person with Medicare returns to Original Medicare, it may be advisable to purchase Medicare Supplement (Medigap) insurance and to enroll in a Medicare Part D prescription drug plan.

Important: If an MA plan member joins a different MA plan, he or she will automatically be disenrolled from the first MA plan upon enrollment in the new MA plan.

WHAT TO CONSIDER BEFORE JOINING A MEDICARE ADVANTAGE PLAN

Refer to the www.medicare.gov web site or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week for the most recent listing of Medicare Advantage (MA) plans available in a county. If your client lives in a county served by more than one MA plan, they can compare benefits, costs and other features to find which plan best suits their needs at a price they can afford. (By using the Medicare Plan Finder at www.medicare.gov/plan-compare/, counselors and people with Medicare can acquire the information needed.)

A person with Medicare should ask each MA plan he or she is considering for a copy of their Summary of Benefits and Evidence of Coverage. Beneficiaries should never rely on advertisements and should check the Star Rating for any plan they are interested in. The client needs to learn about their rights and the nature and extent of coverage. After the information is reviewed, the person with Medicare should ask:

Cost: What is the MA plan's monthly plan premium? What co-payment(s) will one have to pay?

A person with Medicare will have to continue to pay their Medicare Part B premium. Some MA plans charge a premium in addition to the Medicare Part B premium, while others do not. MA plans usually charge a co-payment when services are received.

Additional Services: Does the MA plan offer services in addition to those covered under Original Medicare?

All MA plans must provide the same basic health benefit package available under Original Medicare. Most plans also offer limited coverage for dental care, hearing aids and eyeglasses. Most MA plans also offer Medicare Part D (Medicare Prescription Drug Coverage) to their members. (For details see Module 6, HIICAP Notebook: *Medicare Prescription Drug Coverage (Medicare Part D.*) https://aging.ny.gov/hiicap-notebook

Find out by asking about additional services: What benefits are available for a routine physical; vision care; dental care; hearing aids?

Reference: If the counselor or person with Medicare does not have access to the Internet to view the Medicare Plan Finder at www.medicare.gov/plan-compare, they may check their Medicare & You Handbook or call 1-800-MEDICARE, 24 hours a day/7 days a week, for a listing of county-specific Medicare Advantage plans.

Additional Considerations for HMO Plan Members

Care outside the HMO network

What if a member wants to receive health care services outside the HMO, wants to get a second opinion outside the HMO, or needs to see a specialist that does not contract with the HMO?

Neither the HMO nor Medicare will cover care outside the HMO network except for emergency or urgently needed care or for out-of-area dialysis care. In addition, HMOs must cover out-of-network specialist care if they do not have an in-network specialist. However, a referral from the primary care physician and prior authorization from the HMO is still required.

Emergency Care

What is a medical emergency? How do members get emergency care if they are in a Medicare HMO Plan?

An Emergency Medical Condition is defined as a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual (or in the case of a pregnant woman, the health of the unborn child)
2. Serious impairment to bodily functions
3. Serious dysfunction of any body organ or part"

HMOs are required to provide access to emergency and urgently needed care services 24 hours a day/7 days a week. The plan must pay for emergency care and cannot require prior authorization for emergency care received from any provider. A person with Medicare can receive emergency care anywhere in the United States. When a beneficiary receives emergency care, the doctor or hospital that provides the service should bill the beneficiary's HMO. If the beneficiary receives the bill, they should send it to the HMO and keep a copy for their own records.

Following a medical emergency, the HMO must also pay for necessary care before the condition is stable enough for the beneficiary to return to their plan's providers. If the beneficiary's condition

allows them to return to the plan's service area, they will need to get follow-up care from their Medicare HMO plan's provider.

A beneficiary (or a family member or friend) should let the plan know of emergencies as soon as medically possible. If what the beneficiary believed was an emergency turns out not to be, the plan must still pay. A member should always appeal a denial of payment for emergency services. Refer to Module 10, HIICAP Notebook: *Medicare Claims and Appeals.*
https://aging.ny.gov/hiicap-notebook

Urgently Needed Care

What is "urgently needed care?" How does a member get urgently needed care if in a Medicare HMO Plan?

Urgently needed services are defined as covered services provided when a beneficiary is temporarily absent from the HMO's service area (or, under unusual and extraordinary circumstances, provided when the beneficiary is in the service area but their contracting medical provider is temporarily unavailable or inaccessible) and when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury or condition; and
2. It is not reasonable given the circumstances to obtain the services through the contracting medical provider.

Care outside the United States

Under what conditions will the HMO pay for health care if a member is traveling outside the United States?

Generally, Original Medicare will not pay for care outside the United States, but Medicare HMO plans may cover worldwide emergency care as an additional benefit. It is important to inquire about this before making travel arrangements to avoid unnecessary medical bills.

CHOOSING THE MEDICARE ADVANTAGE OPTION

Medicare Advantage (MA) plans provide all Medicare-covered services and receive payment directly from Medicare for the care a person with Medicare needs. MA plans also provide additional benefits. For instance, most MA plans offer limited coverage for dental care, hearing aids and eyeglasses.

If a person with Medicare joins a Medicare HMO plan, they must obtain services from the health care professionals and facilities that are part of the HMO plan network except for emergency or urgently needed care, or out-of- area dialysis care. The person with Medicare selects a primary care physician (PCP) from those affiliated or under contract with the HMO plan. That doctor coordinates your client's care by providing health care and arranging for them to see other providers when necessary.

If your client enrolls in any type of Medicare Advantage (MA) plan, they must continue to pay their Part B monthly premium including any Part B or Part D Income Related Monthly Adjustment Amount (IRMAA). This premium is usually withheld from their monthly Social Security check.

Your client may also have to pay co-payments when they see a provider and a monthly premium to the MA plan. In return, the MA plan provides your client with all Medicare hospital and medical benefits.

A person with Medicare will not need a Medigap policy if they join a Medicare Advantage plan, since they will not be able to collect on the Medigap policy benefits. If your client already has a Medigap policy to supplement their fee-for-service Medicare or Original Medicare coverage and they decide to join a Medicare Advantage plan, they should be advised to discontinue their Medigap policy, because it is not needed.

Caution: Please note that if your client has a retiree plan (including employer sponsored MA and PDP plans), they should be very cautious about giving it up to join a Medicare Advantage plan instead because in most cases, they will not be able to get this retiree plan benefit back again.

Who can enroll in a Medicare Advantage plan?

Most Medicare beneficiaries are eligible to enroll. A person with Medicare can enroll in a Medicare Advantage plan if they:

- live in the plan's service area
- are enrolled in both Medicare Part A and Part B
- Since 2021, people with End-stage Renal Disease (ESRD) are now eligible to enroll.

Medicare Advantage (MA) plans cannot delay coverage for pre-existing conditions. A person with Medicare cannot be rejected because of their age or health status.

WHY JOIN A MEDICARE ADVANTAGE PLAN?

Predictable Payments and Lower Costs

Medicare Advantage (MA) plans limit out-of-pocket payments and have predictable co-payment amounts for most services. These features may give a person with Medicare more control over their health care costs.

All Medicare Advantage plans must have yearly Maximum Out-of-Pocket (MOOP) amounts for all Part A and B covered services. These amounts cannot exceed $7,550 (HMO) and $11,300 (PPO), including $7,550 in-network. Although these are the highest amounts that plans may have, some MA plans have a lower MOOP. (MOOP does NOT include the plan premium, any cost-sharing for extra benefits not covered by Medicare and any Part D drug cost-sharing.) Once a beneficiary has reached the MOOP, Part A and B covered services are provided at 100% for the remainder of the calendar year.

Note: MA plans must provide all in-network preventive services that are covered at zero cost-sharing under Original Medicare at zero cost-sharing. This means no deductible and no co-pay.

People with Medicare enrolled in a Medicare Advantage plan also do not need Medigap insurance, since MA plans provide all or most of the benefits provided by Medicare and a Medigap policy.

Note: In New York State if a person with Medicare enrolls in an MA plan and later returns to Original Medicare, they will be able to buy a Medigap insurance policy regardless of age or health status at any time. However, there could be a pre-existing condition waiting period if there is more than a 63-day lapse in coverage.

More Benefits

Medicare Advantage (MA) plans offer benefits that are not available under Medicare's fee-for-service program. For example, MA plans may offer limited coverage for dental care, hearing aids, and eyeglasses.

Less Paperwork

The member simply shows their membership card, pays the required co-payment and receives services. A member does not have to complete any paperwork.

The only exception is if a member pays out-of-pocket for **emergency** or **urgently needed** care. Then they may have to send a claim form and other information to the MA plan for payment or reimbursement.

Educational Services

Medicare Advantage plans often provide ongoing health education classes and information to encourage healthier lifestyles.

TOOL TO HELP WITH DECISION-MAKING

The Medicare Plan Finder can help make health plan choices. This service is at www.medicare.gov/plan-compare on the internet or one can call 1-800-MEDICARE (1-800-633-4227). Callers can speak with a customer service representative at 1-800-MEDICARE 24 hours a day, including weekends.

QUALITY OF CARE

Medicare Advantage plan quality comparison information is available in the Medicare Plan Finder section of the Medicare web site www.medicare.gov/plan-compare. Plans receive an overall rating of 1 (poor) to 5 (excellent) stars. If you want more detail, you can see the actual numbers or percentages that go into each of 5 different categories that make up these overall ratings. These categories include:

- **Staying healthy: screenings, tests, and vaccines.** Includes whether members got various screening tests, a yearly flu shot, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions.** Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- **Member experience with the health plan.** Includes ratings of member satisfaction with the plan.
- **Member complaints, problems getting services, and improvement in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members filed complaints against the plan and choose to leave the plan. Includes how much the plan's performance has improved (if at all) over the last two years.

- **Health plan customer service.** Includes how well the plan handles calls from members, makes decisions about member appeals for health coverage, and handles new enrollment requests in a timely way.

People with Medicare may also wish to check with the New York State Department of Financial Services at **1-800-342-3736** to see if complaints have been filed against the health insurer that offers the Medicare Advantage plan.

Note: Complaints about the quality of care received from Medicare providers should be directed to the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) in New York State, **Livanta**, at **1-866-815-5440.** https://www.livantaqio.com/

APPEAL RIGHTS

Refer to Module 10, HIICAP Notebook: *Medicare Claims and Appeals,* for information on appealing a denial of coverage for services provided to Medicare Advantage plan members. https://aging.ny.gov/hiicap-notebook

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

1-800-MEDICAR(E) **1-800-633-4227**

https://www.medicare.gov 24 hours day/7 days a week

TTY 1-877-486-2048

NY Connects (NYS Office for the Aging) **1-800-342-9871**
https://www.nyconnects.ny.gov/

LIVANTA, LLC **1-866-815-5440**
BFCC-QIO TTY 1-866-868-2289
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
https://www.livantaqio.com/en/states/new_york

Additional Resources

- *Understanding Medicare Advantage Plans,* CMS Publication #12026
  - https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf
- *Understanding your Medicare Advantage Plan's provider network,* CMS Publication #11941
  - https://www.medicare.gov/Pubs/pdf/11941-Understanding-Your-Medicare-Advantage-Plan.pdf
- *Understanding Medicare Part C & Part D Enrollment Periods,* CMS Publication#11219
  - https://www.medicare.gov/Pubs/pdf/11219-understanding-medicare-part-c-d.pdf
- *A Quick Look at Medicare*, CMS Publication #11514
  - https://www.medicare.gov/Pubs/pdf/11514-A-Quick-Look-at-Medicare.pdf
- *Special Needs Plans (SNP)*
  - https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/special-needs-plans-snp
- *Medicare Medical Savings Account (MSA) Plans*
  - https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans
- *Quick Facts About Programs of All-inclusive Care for the Elderly (PACE)* - CMS Publication #11341
  - https://www.medicare.gov/Pubs/pdf/11341-PACE.pdf

- NY Medicaid Choice at 1-800-505-5678, or visit https://www.nymedicaidchoice.com/.
- Help with long -term care services – Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 or visit https://www.icannys.org

STUDY GUIDE MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.

What do all Medicare Health Plans have in common?

2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?

In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare program.
- All Medicare Health Plans **must** provide all Medicare-covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, and must live in the service area of the MA plan.
- Not all of the Medicare Advantage Health Plan Choices are available in all areas.
- People with Medicare must be advised of when they can enroll in a Medicare Advantage plan, switch to Original Medicare or change to another MA plan.
- If your client is happy with the way they get health care now, they do not have to do anything. Your client will continue to receive their Medicare health care in the same way they always did.

ANSWER KEY MODULE 5: MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

1. MEDICARE ADVANTAGE HEALTH PLAN OPTIONS

Read your *HIICAP Notebook* to learn about all of the Medicare Advantage Options.

What do all Medicare Health Plans have in common?

All Medicare Health Plans must provide all Medicare-covered services.

2. WHY JOIN A MEDICARE ADVANTAGE (MA) PLAN?

Because a person with Medicare may receive extra benefits that Original Medicare does not offer such as dental benefits, hearing aids, eyeglasses and more. With an MA plan, a person with Medicare does not need a Medicare Supplement/Medigap plan and their costs may be more predictable and limited to an out-of-pocket maximum.

In summary: Consider what you have learned in this Medicare Advantage Module:

- No matter what your client decides, they are still in the Medicare Program.
- All Medicare Health Plans **must** provide all Medicare-covered services.
- To be eligible for any of the Medicare Advantage (MA) plan choices, a person with Medicare must have Medicare Part A **and** Part B, and must live in the service area of the MA plan.
- **Not** all of the Medicare Advantage Health Plan Choices are available in all areas.
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