NEW YORK STATE OF OPPORTUNITY. Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program

Technical Assistance Center

Module 5: MEDICARE ADVANTAGE PLANS

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MODULE 5 LEARNING OBJECTIVES

1. Describe the types of Medicare Advantage Plan options.
2. Support clients in choosing a Medicare Advantage Plan and enrolling in it.

MEDICARE ADVANTAGE BASICS AND ELIGIBILITY

People can choose to get their Medicare through Original Medicare or through a Medicare Advantage Plan, also known as an MA Plan, a Medicare private health plan, or Part C. Medicare Advantage Plans contract with the federal government and are paid a fixed amount per enrollee to provide Medicare benefits.

An individual still has Medicare if they enroll in a Medicare Advantage Plan. They will just get their Part A and Part B coverage from the Medicare Advantage Plan, not Original Medicare. Someone enrolled in a Medicare Advantage Plan should receive all the same benefits offered by Original Medicare, but their plan may apply different rules, costs, and restrictions, which can affect how and when beneficiaries receive care. For example, beneficiaries will generally get their services from a plan's network of providers. Some Medicare Advantage Plans may also offer certain benefits that Original Medicare does not cover.

In most cases, a 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, though, because they will need it if they ever switch back to Original Medicare.

To be eligible for one of the Medicare Advantage health plan choices, an individual 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, they can call the Social Security Administration (SSA) at 1-800-772-1213 or call 1-800-MEDICARE (1-800-633-4227). They can also create an SSA account.

- Live in the service area of a health plan. The service area is the geographic area where the plan accepts enrollees. It is also the area where services are provided (for plans that require an enrollee to use their doctors and hospitals). The plan may disenroll a member if they move out of the plan's service area. If someone is disenrolled, they are automatically covered under Original Medicare. A beneficiary who moves to a new area may be able to join a Medicare Advantage Plan in their new area if one is available. A person who is incarcerated does not live in a plan service area.

A plan cannot reject a beneficiary because of their age or health status and cannot delay coverage for pre-existing conditions. 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.

The most common types of Medicare Advantage Plans are:

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Private Fee-for-Service (PFFS)

You may also see:

- Medical Savings Accounts (MSAs)
- Special Needs Plans (SNPs)
- Provider Sponsored Organizations (PSOs)

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

If someone has health coverage from their union or employer when they become eligible for Medicare, they may automatically be enrolled in a Medicare Advantage Plan sponsored by that union or employer. Beneficiaries have the choice to stay with this plan, switch to Original Medicare, or enroll in a different Medicare Advantage Plan. Clients should know that if they disenroll from this sponsored Medicare Advantage Plan, their union or employer could terminate or reduce the client's benefits.

People may have additional plan options if they are enrolled in both Medicare and Medicaid and also need long-term care services (see HIICAP Notebook Module 14).

MEDICARE ADVANTAGE COSTS

Beneficiaries choosing a Medicare Advantage Plan should be aware of the different cost-sharing they may face.

- Premiums: Medicare Advantage enrollees generally must pay the Part B premium (and Part A premium if they owe one). In some cases, the plan may pay part of an enrollee's Part B premium.

Plans may charge their beneficiaries an additional premium for being enrolled in the Medicare Advantage Plan.

- Deductibles: Medicare Advantage Plans may charge a deductible for services, including inpatient, outpatient, and prescription drugs. Deductibles vary by plan.
- Copayments: Medicare Advantage Plans usually charge a copayment (copay) for doctor's visits, instead of the 20% coinsurance people pay under Original Medicare. Plans may set their copayments, but keep in mind that plans cannot charge higher copays than Original Medicare for certain care, including chemotherapy, dialysis, and skilled nursing facility care. However, plans can charge higher copays for other services, including home health, durable medical equipment, and inpatient hospital care.

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

All Medicare Advantage Plans must set an annual limit on out-of-pocket costs, known as the maximum out-of-pocket (MOOP). This limit is high, but it may protect beneficiaries from very high out of pocket costs if they need a lot of care or expensive treatments. After reaching the MOOP, beneficiaries will not owe cost-sharing for Part A or Part B covered services for the remainder of the year. Some plans may also apply the MOOP to supplemental benefits, such as vision, hearing, or dental.

The out-of-pocket costs that help a beneficiary reach their MOOP include all cost-sharing (deductibles, coinsurance, and copayments) for Part A and Part B covered services that they receive from in-network providers. Part D cost-sharing does not count towards the plan's MOOP. Medicare sets a MOOP each year for Medicare Advantage Plans, but plans may set lower limits for their beneficiaries. In 2026, the MOOP is $9,250. Plans that cover services from out-of-network providers, such as PPOs, will set two annual limits on out-of-pocket costs. One limit is for in-network costs and the other is for combined in-network and out-of-network costs. Clients should call their plan directly if they have questions about their annual out-of-pocket limit.

Remember that Medicare Advantage enrollees cannot buy a Medigap policy to supplement their plan and cover cost-sharing. Medigap policies only work with Original Medicare. (See HIICAP Notebook Module 7: Medicare Supplemental Insurance/Medigaps).

MEDICARE ADVANTAGE COVERAGE

Clients should remember that Medicare Advantage Plans have different coverage rules. For example, though Medicare Advantage Plans must cover the same health services that Original Medicare covers, they may ask beneficiaries to take certain steps before the plan will pay for their care. A plan may require a beneficiary's doctor to ask the plan's permission before providing certain services. A plan may also require more formal referrals to see specialists or prior authorization for certain services.

Many plans cover services only if beneficiaries receive them from doctors, hospitals, and pharmacies that are in the plan's network. Before joining a plan, clients should make sure their doctors (or other providers they may want to use in the future) are in the network and that they are accepting new patients from the plan. Keep in mind that doctors and hospitals may leave the plan at any time, but beneficiaries can only leave a Medicare Advantage Plan during an enrollment period if they want to avoid penalties.

Medicare Advantage Plans can cover items or services not covered by Original Medicare, which are called supplemental benefits. These benefits do not need to be provided by Medicare providers or at Medicare-certified facilities. Instead, to receive these items or services, beneficiaries need to follow the plan's rules. Some commonly offered supplemental benefits are dental care, vision care, hearing aids, and gym memberships.

Supplemental benefits can either be:

- Optional, meaning that they are offered to everyone who is enrolled in a plan, and beneficiaries can choose to purchase the benefits if they want to, or
- Mandatory, meaning that they are covered for everyone enrolled in a plan and a beneficiary cannot decline the coverage (even if they do not need to use the service).

Medicare Advantage Plans can also cover supplemental benefits that are not primarily health-related for beneficiaries who have chronic illnesses. These benefits should address social determinants of health. A social determinant of health is part of someone's life that can affect their health in some way, such as not having access to transportation. Plans can offer benefits that are not primarily health-related like meal delivery, transportation for non-medical needs, and home air cleaners. In order to be eligible for these benefits, a beneficiary must be chronically ill. To be considered chronically ill for the purpose of accessing these benefits, the plan must determine that beneficiaries meet all of the following:

- Have at least one medically complex condition that is life-threatening or significantly limits health or function
- Have a high risk of hospitalization or other negative health outcomes
- Require intensive care coordination

Since Medicare Advantage Plans will be able to create sets of supplemental benefits for people with specific chronic illnesses, not every member of a Medicare Advantage Plan will have access to the same set of benefits. For example, a plan might cover services like home air cleaning and carpet shampooing for members with severe asthma. A member of that plan who has severe asthma will be able to get those services covered, while a member who does not have asthma, or whose asthma is mild, will not.

TYPES OF MEDICARE ADVANTAGE PLANS

Health Maintenance Organizations (HMOs)

- **Providers**: Beneficiaries need to select a primary care provider (PCP) who coordinates their care. Beneficiaries usually must get their PCP's permission or referral before seeing a specialist.

Beneficiaries are generally only covered for care they get from in-network providers and facilities. Except in emergencies or urgent care situations, beneficiaries will pay the full cost of the care they receive from out-of-network providers. Keep in mind that doctors may leave the HMO's network at any time, even during the plan year. If a beneficiary needs emergency or urgent care and they are outside the plan's service area, the plan must cover the care even if it is provided by an out-of-network doctor. 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. (See HIICAP Notebook Module 12: Medicare Appeals.)

  - Some HMOs offer a point-of-service (POS) option, which allows beneficiaries to see out-of-network providers for certain services without referral or prior authorization. Beneficiaries may pay more than they would when seeing an in-network provider, but plans must have a limit on out-of-pocket costs with the POS option.

- **Benefits:** If a beneficiary wants Part D coverage, they must receive coverage from their plan. They cannot enroll in stand-alone Part D coverage with their HMO. An HMO may offer additional benefits, such as vision, hearing, or dental care.
- **Costs:** HMOs may charge a monthly premium in addition to the Part B premium or choose to pay part of a beneficiary's Part B premium. Plans may charge a higher premium if they also include Part D coverage. All HMOs must set an annual limit on beneficiaries' out-of-pocket costs. Medicare sets a yearly maximum out-of-pocket limit for HMOs, but plans may set lower limits.

Preferred Provider Organizations (PPOs)

- **Providers:** Beneficiaries are not required to select a PCP. They can see a specialist without a referral. Enrollees can see any provider, but generally must pay more when seeing out-of-network providers.
  - Note: Some companies may offer a Regional PPO (RPPO) that serves the entire state of New York, rather than select counties. Currently, UnitedHealthCare is the only company offering a RPPO in New York State. Other companies may offer PPO plans only in certain counties of the state.
- **Benefits:** If a beneficiary wants Part D coverage, they must receive coverage from their plan. They cannot enroll in stand-alone Part D coverage with their PPO. A PPO may offer additional benefits, such as vision, hearing, or dental care.
- **Costs:** Many PPOs charge a monthly premium in addition to the Part B premium and may charge a higher premium if they also have Part D coverage. Premiums are usually more than HMO premiums, but less than premiums for Medicare Supplement insurance. PPOs typically set fixed copays for in-network services and may charge more if a beneficiary sees an out-of-network provider. PPOs set two annual limits on out-of-pocket costs. One limit is for in-network costs and the other is for combined in-network and out-of-network costs.

Private Fee-for-Service (PFFS) plans

- **Providers:** Beneficiaries are not required to select a PCP and can see a specialist without a referral. Beneficiaries can see any Medicare-participating medical provider or any hospital (if the provider or hospital accepts the plan's payment terms), but generally must pay more when seeing out-of-network providers. If a beneficiary plans to receive care from an out-of-network provider, they or their provider can request an advance organization determination (also called an advance coverage determination) from the plan. An advance organization determination is a request for the plan to confirm that a service is medically necessary and will be covered. If an individual plans to receive a costly service from an out-of-network provider, requesting an advance organization determination can help them avoid unexpected denials.
- **Benefits:** If a beneficiary wants Part D coverage, their PFFS plan may offer it. If not, the beneficiary can enroll in a stand-alone Part D plan. The plan may offer additional benefits, such as vision, hearing, or dental care.
- **Costs:** Many plans charge a monthly premium in addition to the Part B premium and may charge a higher premium if they also have Part D coverage. All plans must set an annual limit on beneficiary out-of-pocket costs. Medicare sets a yearly maximum out-of-pocket for PFFS plans, but plans may set lower limits.

Medicare Medical Savings Account (MSA)

- **Providers:** MSA plans cover in-network care (if the plan has a network), as well as out-of-network care. However, beneficiaries owe the least when seeing in-network providers. If the plan does not have a provider network, beneficiaries pay the least when seeing participating providers, meaning providers who take Medicare assignment. These providers will only charge the Medicare-approved amount.
- **Benefits:** MSA plans do not provide Part D coverage, so beneficiaries must join a stand-alone Part D plan for such coverage. Out-of-pocket expenses for prescription drugs do not count toward meeting an MSA plan's deductible. MSAs plan may offer additional benefits, such as vision, hearing, and/or dental care.
- **Costs:** MSA plans typically do not charge a monthly premium in addition to the Part B premium, but some may. MSA plans work with a high deductible health plan (HDHP) and a bank account. A plan deposits funds for a beneficiary's medical expenses into the bank account, and the beneficiary can then use these funds to pay for care. A beneficiary will likely have high out-of-pocket costs for their care until they reach their deductible. After reaching the deductible, the MSA plan covers 100% of the cost for Medicare-covered services.
    - Funds contributed to an MSA are not taxed if they are used to pay for qualified medical expenses. The MSA can be used to pay for non-Medicare covered medical expenses such as for dental care, vision care, or hearing aids, but only payments made for Medicare covered expenses will be credited toward the plan deductible. Beneficiaries can use MSA funds for other expenses, but those funds will be taxed and will not count toward the HDHP

deductible. Any remaining money in the bank account at the end of the year remains in the account for the next year, in addition to the plan's regular yearly contribution.

- If someone joins an MSA plan after January 1, their yearly deductible will be pro-rated to the number of months left in the year. Beneficiaries keep any money left in the account if they leave the MSA plan at the end of the year. They will not be taxed if they use the money left in the account for qualified medical expenses. If they leave the plan midyear, part of the money will be refunded to Medicare depending on the number of months left in the year.

Special Needs Plan (SNP)

All SNPs are designed to meet specific care needs, and beneficiaries can only join a SNP if they fit the special needs category the plan serves. SNPs may provide care and coverage coordination services not offered by other types of Medicare Advantage Plan. There are three types of SNPs:

- Chronic Condition SNPs (C-SNPs): For individuals with specific chronic conditions, such as cancer, dementia, diabetes, HIV/AIDS, stroke, End-Stage Renal Disease (ESRD), and certain neurologic disorders.
- Institutional SNPs (I-SNPs): For individuals who live in an institution, such as a nursing home, long-term care skilled nursing facility, intermediate care facility, or assisted living facility.
- Dual Eligible SNPs (D-SNPs): For individuals enrolled in Medicare and Medicaid.

A SNP may be an HMO or a PPO. Depending on the plan, beneficiaries may need to see in-network providers to receive coverage or have the option of going out of network. Plans may charge a monthly premium in addition to the Part B premium. All SNPs are required to provide Part D coverage.

CHOOSING A MEDICARE ADVANTAGE PLAN

HIICAP counselors cannot endorse a particular Medicare Advantage Plan but can help clients get information needed to decide if a plan meets their needs. Not all Medicare health plan choices may be available in your client's area. A client's Medicare & You handbook lists the Medicare health plan choices available in their area at the time the handbook is published.

Medicare Plan Finder can also help beneficiaries make health plan choices. In addition to accessing this tool online, beneficiaries can call 1-800-MEDICARE (1-800-633-4227) for detailed information on Medicare Advantage options. TTY users should call 1-877-486-2048. Callers can speak with a customer service representative at 1-800-MEDICARE 24 hours a day, including weekends.

When a client is choosing between multiple Medicare Advantage Plans, or choosing between Original Medicare and Medicare Advantage, here are some questions they should be asking:

- Providers, hospitals, and other facilities: Will I be able to use my doctors? Are they in the plan's network? Do doctors and providers I want to see in the future take new patients who have

this plan? If my providers are not in-network, will the plan still cover my visits? Which specialists, hospitals, home health agencies, and skilled nursing facilities are in the plan's network?

- Access to health care: What is the service area for the plan? Do I have any coverage for care received outside the service area? Who can I choose as my Primary Care Provider (PCP)? Does my doctor need to get approval from the plan to admit me to a hospital? Do I need a referral from my PCP to see a specialist?
- Costs: What costs should I expect for my coverage, such as premiums, deductibles, and copayments? What is the annual maximum out-of-pocket (MOOP) cost? How much will I have to pay out of pocket before coverage starts, or in other words, what is the deductible? How much is my copayment for services I regularly receive, such as PCP or specialist care? How much will I pay if I visit an out-of-network provider or facility? Are there higher copays for certain types of care, such as hospital stays or home health care?
- Benefits: Does the plan cover any services that Original Medicare does not, such as dental services, vision care, or hearing aids? Are there any rules or restrictions I should be aware of when accessing these benefits?
- Prescription drugs: Does the plan cover outpatient prescription drugs? Are my prescriptions on the plan's formulary? Does the plan impose any coverage restrictions? What costs should I expect to pay for my drug coverage, like premiums, deductibles, and copayments? How much will I have to pay for brand-name drugs? How much for generic drugs? What will I pay for my drugs during the coverage gap? Will I be able to use my pharmacy? Can I get my drugs through mail order? Will the plan cover my prescriptions when I travel?
- Coordination of benefits: How does the plan work with my current coverage? If I join, would I lose my job-based insurance or retiree coverage?

A person with Medicare should ask each plan they are considering for a copy of their Summary of Benefits and Evidence of Coverage. Beneficiaries should never rely only 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.

Medicare Advantage Plan quality comparison information is available in the Medicare Plan Finder section of the Medicare website. Plans receive an overall rating of 1 (poor) to 5 (excellent) stars. If you or the client wants 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, which is Livanta, at 1-866-815-5440.

ENROLLING IN A MEDICARE ADVANTAGE PLAN

There are certain times each year when someone can enroll in a Medicare Advantage Plan. It is usually best to enroll in a plan by calling 1-800-MEDICARE, rather than by calling the new plan. Beneficiaries can typically enroll in Medicare Advantage during the following periods:

Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for Medicare Advantage may make an initial enrollment request to enroll in a 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 second month after the month in which the individual is first entitled to Part A and enrolled in Part B

Fall Open Enrollment Period

Eligible Medicare beneficiaries can enroll in a Medicare Advantage plan or switch their plan choice (either Medicare Advantage or Prescription Drug Plan) during the Fall Open Enrollment Period. This period, also sometimes called the Annual Election Period (AEP), 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 (MA OEP)

During the MA 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 Medicare Advantage 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.

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

Special Enrollment Period (SEP)

An 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. Listed below are details on two specific SEPs. For a full list of SEPs and requirements, please see the Part C and D Special Enrollment Period Chart from the Medicare Rights Center.

5-star SEP: A beneficiary can switch to a Medicare Advantage Plan that has an overall 5-star rating from December 8 to November 30. Beneficiaries can only use this SEP once during this time frame.

SEP65: People with Medicare who enroll in a Medicare Advantage Plan (other than an MSA plan) during the Initial Enrollment Period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from this Medicare Advantage Plan and elect Original Medicare any time during the 12-month period that begins on the effective date of coverage in the Medicare Advantage Plan. Note that the SEP65 can only be used to return to Original Medicare.

Note: There is a new, temporary SEP for Incorrect Medicare Plan Finder Medicare Advantage Provider Directory Information. In Fall 2025, Medicare Plan Finder incorporated provider directory information to help beneficiaries when comparing Medicare Advantage Plans. This new, temporary SEP is for any beneficiary who relied on provider directory information during the first year of the Medicare Plan Finder provider directory, and, within 3 months of the effective date of that coverage, discovered that the directory information was inaccurate and their preferred provider is not in the plan's network.

Medicare will grant an SEP to beneficiaries who:

- Used Medicare Plan Finder provider directory information to select a Medicare Advantage Plan

- Enrolled in that plan through Medicare Plan Finder
- And, within three months of the effective date of the plan, realize that their preferred provider is not in the plan's network.

To use this SEP, a beneficiary will need to call 1-800-MEDICARE (633-4227) so that a Medicare representative can confirm that the enrollment happened directly through Medicare Plan Finder and then make the requested enrollment change. Beneficiaries can choose to enroll in a different Medicare Advantage Plan or switch to Original Medicare with or without a Part D plan. The requested change will be effective the first day of the following month, not retroactively.

Remember that this SEP is temporary and only for beneficiaries with Medicare Advantage Plan effective dates of 1/1/2026 through 12/1/26.

Disenrolling from a Medicare Advantage Plan

If a plan member joins a different Medicare Advantage Plan, they will automatically be disenrolled from the first plan upon enrollment in the new plan. The beneficiary could also call 1-800-MEDICARE (1-800-633-4227) or send a signed request to the plan to disenroll when eligible but is not required to do so.

However, if someone with a Medicare Advantage Plan wants to switch to Original Medicare, simply not paying Medicare Advantage Plan premiums anymore does not guarantee that the beneficiary will be disenrolled from the plan. In this instance, the beneficiary should call 1-800-MEDICARE (1-800-633-4227).

Also note that if a beneficiary's Medicare Advantage Plan includes prescription drug coverage and the beneficiary joins a stand-alone Part D plan, the beneficiary will be disenrolled from their Medicare Advantage Plan and returned to Original Medicare.

When someone 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. In New York State, if a person with Medicare enrolls in a Medicare Advantage 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. (See HIICAP Notebook Module 7: Medicare Supplement Insurance/Medigap.)

MID-YEAR CHANGES TO A MEDICARE ADVANTAGE PLAN

Medicare Advantage Plans must notify beneficiaries of any changes they make during the plan year. Typical reasons for sending a notice include changes made to the provider network or formulary.

Network changes: In-network providers can leave a plan at any time. When a provider leaves a plan's network, the plan should send all members who see that provider a written notice at least 30 days before the provider leaves the network.

Mid-year formulary changes: Beneficiaries may receive drug coverage through their Medicare Advantage Plan. If the drug plan makes formulary changes during the year, beneficiaries have certain rights depending on why the plan made the change. Specifically, if the plan is making maintenance changes, they must give the beneficiary 60 days notice or provide a 60 day transition refill. Maintenance changes include:

- Covering a generic drug instead of a brand-name drug, or changing the tier of a brand-name drug after introducing a generic option
- Adding coverage restrictions to a drug
- Removing a non-Part D drug that had been unintentionally included on the formulary
- Making formulary changes based on new clinical guidelines or Food and Drug Administration (FDA) safety concerns

Note: If a drug is declared unsafe by the FDA and withdrawn from the market, a plan can remove the drug from their formulary at any time. Plans should notify affected individuals, but they are not required to give 60 days' notice.

Plans may make other changes that are not considered maintenance changes. If a plan makes other formulary changes, and a beneficiary is taking an affected drug, the plan must allow the beneficiary to continue taking that drug for the rest of the year as long as it is medically necessary. The plan should send the beneficiary a notice explaining that they are exempt from the change for the rest of the year.

Plans should send beneficiaries an updated copy of the formulary in the mail if they are affected by any changes. The plan should also update accessible formulary information online and in print.

Sources of Assistance

NYSOFA HIICAP Hotline
1-800-701-0501

Medicare
1-800-MEDICARE (1-800-633-4227)
Call for questions about Medicare coverage, claims, or how Medicare works with your clients' other insurance. Available in English and Spanish.
http://www.medicare.gov

Social Security Administration
Hotline: 1-800-772-1213
Fax: 1-833-914-2016

Call for Medicare eligibility and enrollment information, lost Medicare card replacement and general Social Security issues. Visit www.ssa.gov/locator to find your local SSA office and contact information for that office.

Benefits Coordination & Recovery Center (BCRC)
1-855-798-2627 (TTY 1-855-797-2627)
Call the BCRC with any changes in insurance coverage or any questions about who pays first.

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

Special Needs Plans
https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP

Medicare Medical Savings Account (MSA) Plans
https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/MSA