Medicare Minute Teaching Materials – April 2020
Choosing between Original Medicare and Medicare Advantage

1. What are Original Medicare and Medicare Advantage?

People with Medicare can choose to get their health coverage through either Original Medicare or a Medicare Advantage (MA) plan (also known as a Medicare private health plan or a Medicare Part C plan). It is important to know how these two approaches to delivering Medicare coverage differ.

Original Medicare is the traditional fee-for-services program offered directly through the federal government. Original Medicare consists of Part A (Hospital Insurance) and Part B (Medical Insurance). It is sometimes called traditional Medicare or fee-for-service (FFS) Medicare. Under Original Medicare, the government pays directly for the health care services you receive. You can go to any doctor and hospital that takes Medicare, anywhere in the country. In Original Medicare:

- You go directly to the doctor or hospital when you need care. You do not need to get authorization from Medicare or a referral your primary care doctor for most services.
- You are responsible for a monthly premium for Part B. Some also pay a premium for Part A.
- You typically owe a coinsurance charge, or percentage of the Medicare's approved payment amount for each service you receive (see question 4).
- Medicare supplement (Medigap) policies are available to help cover Original Medicare's out-of-pocket costs (see question 2).
- There are limits on the amounts that doctors and hospitals can charge for your care.

If you want prescription drug coverage with Original Medicare, in most cases you will need to actively choose and join **a stand-alone Medicare private drug plan**, also called a Part D plan. Part D is offered through private insurance companies. If you have Original Medicare, you may choose to purchase supplemental insurance to help pay out-of-pocket costs, commonly called a "Medigap plan."

Unless you choose otherwise, you will have Original Medicare when you first enroll in Medicare.

Medicare Advantage plans, also known as Medicare private health plans or Part C plans, contract with the federal government and are paid a fixed amount per person to provide Medicare benefits. The most common types of Medicare Advantage plan are:

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

You may also see:

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

Remember, you still have Medicare if you enroll in an MA plan. This means that you likely pay a monthly premium for Part B (and a Part A premium, if you have one). If you are enrolled in an MA plan, you should receive the same benefits offered by Original Medicare, and many MA plans include prescription drug coverage.

In Medicare Advantage plans:

- You generally need to see providers who are in your plan's network and service area to pay the lowest cost for services. In many plans, you must get prior authorization or a referral from your primary care provider for specialty services, procedures, and durable medical equipment.
- You will often pay fixed copayments per service or item you receive. These costs vary from plan to plan. Plans cannot charge higher copayments or coinsurances than Original Medicare for certain services, like chemotherapy and dialysis, but they can charge higher cost-sharing for other services.
- All Medicare Advantage plan must include a limit on your out-of-pocket expenses for Part A and B services. For example, the maximum out-of-pocket cost for HMO plans in 2020 is $6,700. An MA plan may offer certain benefits that Medicare does not cover, such as dental and vision care, caregiver counseling and training, and certain in-home support like housekeeping. Not all MA plans cover additional benefits, so check with a plan directly to learn what benefits it covers.

MA plans may have different:

- Networks of providers
- Coverage rules, including prior authorization and referral requirements, that can constrain how and when you receive care
- Premiums (in addition to the Part B premium)
- Cost-sharing, including deductibles and copayments for covered services (see question 4)

Even plans of the same type offered by different companies may have different rules, so you should always check with a plan directly to find out how its coverage works.

You can join an MA plan if:

1. You have Medicare Parts A and B
2. You live in the plan's service area

3. And, you do not have End-Stage Renal Disease (ESRD), except in limited circumstances
    - Note: If you have ESRD and need dialysis or a kidney transplant, you may enroll in an MA plan if you join a Special Needs Plan that specifically accepts people with ESRD or if other special circumstances apply. Additionally, beginning in 2021, people who have ESRD will be able to enroll in any Medicare Advantage plan, as long as they have Medicare Parts A and B and live in its service area.

Many Medicare Advantage plans also offer prescription drug coverage (Part D). If you join an MSA plan or a PFFS plan without drug coverage, you can enroll in a stand-alone Part D plan. Remember that people with Original Medicare who want Part D coverage would also enroll in a stand-alone Part D plan.

If you have health coverage from your union or employer (current or former) when you become eligible for Medicare, you may automatically be enrolled in an MA plan that they sponsor. You have the choice to stay with this plan, switch to Original Medicare, or enroll in a different MA plan. Be aware that if you switch to Original Medicare or enroll in a different MA plan, your employer or union could terminate or reduce your health benefits, the health benefits of your dependents, and any other benefits you get from your company. Talk to your employer/union and your plan before making changes to find out how your health benefits and other benefits may be affected.

Call 1-800-MEDICARE to learn more about Medicare Advantage and Part D plans available in your area or to change your coverage. Or, use medicare.gov to compare plans: https://www.medicare.gov/plan-compare.

Contact your State Health Insurance Assistance Program (SHIP) if you need help understanding your Medicare options (contact information is at the end of this document).

Contact your Senior Medicare Patrol (SMP) if you believe that you have experienced Medicare fraud, abuse, errors, or high-pressure plan sales tactics (contact information is at the end of this document).

2. What is a Medigap policy?

Medigaps are health insurance policies that offer standardized benefits to work with Original Medicare (not with Medicare Advantage). They are sold by private insurance companies. If you have a Medigap, it pays part or all of certain costs, often called "gaps," that remain after Original Medicare pays first. Medigaps cover some to all outstanding deductibles, coinsurance, and copayments. Medigaps may also cover health care costs that Medicare does not cover at all, like care received when travelling abroad. Remember, Medigaps only work with Original Medicare. If you have a Medicare Advantage plan, you cannot buy a Medigap.

Depending on where you live and when you became eligible for Medicare, you have up to 10 different Medigap policies to choose from: A, B, C, D, F, G, K, L, M, and N (policies in Wisconsin, Massachusetts, and Minnesota

have different names). Each policy offers a different set of standardized benefits, meaning that policies named with the same letter offer the same benefits. However, premiums vary from company to company and from state to state.

Note: People who turn 65 on or after January 1, 2020 or become eligible for Medicare due to disability or ESRD on or after January 1, 2020, cannot purchase Medigaps that pay for the Part B deductible. This includes Plan C and Plan F. If you turned 65 or otherwise became Medicare-eligible before this date, you will still be able to purchase Plan C or Plan F.

Before you buy a Medigap policy, be sure to do your research. For information on choosing between Medigap options, see here: https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf. It covers important topics for purchasing Medigap policies that affect costs, such as guaranteed issue rights and the Medigap Open Enrollment Period.

Some steps you may wish to take include the following:

1. Make sure you are eligible to purchase a Medigap. Remember that you can only have a Medigap if you have Original Medicare. If you are enrolled in a Medicare Advantage plan, Medigaps cannot be sold to you. You also may not have a Medigap sold to you if you have Medicaid. There may be other Medigap eligibility requirements that apply to you, depending on the state in which you live.
2. Learn when you have the right to buy a Medigap without restriction. There are federal protections, including guaranteed issue rights, for people over 65 to buy a Medigap in certain situations. Some states have additional protections for individuals under 65 or during other times.
3. Once you decide you need a Medigap and know you are eligible to enroll, compare the different types of policies that exist. As mentioned above, there are 10 different standardized policies in most states, each covering a different range of Medicare cost-sharing.
4. Learn how a Medigap covers prior medical conditions to know if any of your medical costs may be excluded from Medigap coverage. Depending on your circumstances, a Medigap can exclude coverage for prior medical conditions for a limited amount of time.
5. Find out how Medigap premiums are priced so you can make cost comparisons. It is important to understand the ways that insurers set premiums to find the best deal for you.
6. Have a list of questions to ask when shopping for a Medigap to remind you what you should consider. Buying a Medigap can be complicated; however, using a set of written questions and asking for help when needed can help you stay organized and simplify the process.

Note: SHIP counselors can talk with their supervisor about the availability of an online Medigap Plan Finder for SHIP counselors in your state (courtesy of the SHIP National Technical Assistance Center).

3. What should I consider if I'm deciding between Original Medicare and Medicare Advantage?

It is important to understand your Medicare coverage choices and to pick your coverage carefully. How you choose to get your benefits and who you can get them from can affect your out-of-pocket costs and where you can get your care. Some of the important factors to consider when you are deciding between Original Medicare and Medicare Advantage are:

- **Costs:** What premiums and out-of-pocket costs will I be responsible for (see number 4)?
- **Supplemental insurance:** Will I have the choice to purchase a Medigap policy (see number 2)? How will my retiree coverage work with this choice?
- **Provider access:** What kind of providers can I see? Do I need to use a network of providers or get referrals to see specialists (see number 5)?
- **Drug coverage:** Is there prescription drug coverage included in my coverage or will I need to purchase a separate stand-alone plan (see number 1)?
- **Additional/supplemental benefits:** Are additional services, like vision, hearing, or dental covered (see number 6)?
- **Out-of-pocket limit:** Is there an annual limit on out-of-pocket costs?

4. How do costs compare between Original Medicare and Medicare Advantage?

In Original Medicare, you will be charged for standardized Part A and Part B costs. In 2020, these costs include:

- **Part A premium:** The Part A premium is different depending on your work history. If you or your spouse has worked more than 10 years, you will generally not have to pay a Part A premium. In this case, you are entitled to Part A by paying into the Medicare hospital insurance trust fund for 10 years. If you have worked between 7.5 and 10 years, your Part A premium will be $252/month. If you have worked less than 7.5 years, your Part A premium will be $252/month. Most people receive Part A coverage without paying a premium.
- **Part B premium:** The Part B premium is $144.60 for people with a yearly income below $87,000 ($174,000 for a married couple). If your income is higher than that, you may have to pay an income-related monthly adjustment amount (IRMAA), which is an amount you pay in addition to your Part B premium if your income is over a certain level. With the exception of low-income beneficiaries, most people pay a monthly premium for Part B coverage.
- **Part A deductible and coinsurance:**
    - The hospital deductible (the amount you must pay before Medicare begins covering your costs) is $1,408 per benefit period. A benefit period is the measure of your use of inpatient and skilled nursing facility (SNF) services. A benefit period begins the day you are admitted to a hospital as an inpatient, or to a SNF, and ends the day have been out of the hospital or SNF for 60 days in a row

  - After you meet the deductible, there is no coinsurance for the first 60 days of a covered inpatient hospital stay in a benefit period—hospitals accept Medicare's payment as payment in full. The coinsurance is $352/day for days 61-90 and $704/day for days 91-150.
  - There is no coinsurance for the first 20 days of a covered SNF stay after a qualifying inpatient hospital stay, and the coinsurance for days 21-100 is $176/day.
- **Part B deductible and coinsurance:** In Original Medicare, you will owe an annual Part B deductible of $198 in 2020. After you meet the deductible, there is a coinsurance of 20% of Medicare's approved amount for most services that Part B covers.

Keep in mind that if you have a Medigap, you will be responsible for fewer out-of-pocket costs because the Medigap plans help pay them (see number 2).

If you have a Medicare Advantage Plan, you will be responsible for paying:

- **Part A premium,** if you have one (see above).
- **Part B premium** (see above).
- **A Medicare Advantage plan premium** for many plans. The amount of this premium can vary widely. Note that MA plans may be available within a service area for no additional premium.
- **Medicare Advantage plan deductible:** Your Medicare Advantage plan might have a deductible—an amount you are responsible for paying out of pocket before your plan will begin to cover your services.
- **Copayments and coinsurances:** The cost-sharing for Medicare Advantage-covered services can vary from plan. Contact your plan to learn more about the cost-sharing you'll be responsible for.

If you have a Medicare Advantage plan, your plan has an out-of-pocket limit. This is the maximum amount that you can be required to pay out of pocket for covered services. This amount does not include your Part A or B premiums or your Medicare Advantage plan monthly premium. Plans can have different out-of-pocket limits, but in 2020, the maximum out-of-pocket limit is $6,700 for in-network services and $10,000 for out-of-network services.

5. Which providers should I see in order to pay the least for covered services?

If you have **Original Medicare,** you can see any provider who accepts Medicare payment and new patients. It is important to know, however, that your Part B cost-sharing charges (once you have met your deductible) can vary depending on the type of provider you see. There are three kinds of agreements that Part B providers can have with Medicare about how they will be reimbursed for services they provide to Medicare beneficiaries. **To pay the least for services, see a participating provider when possible.**

- **Participating providers** are physicians, durable medical equipment suppliers, and other health care providers who accept Medicare and always take assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as full payment. These providers are

required to bill Medicare for care you receive. Medicare will process the claim and for most services and items pay your provider 80 percent of the approved amount. If you see a participating provider, you are responsible for 20% of Medicare's approved amount, the Part B coinsurance charge.

- **Non-participating providers** accept Medicare but do not agree to take assignment in all cases. They may do so only on a case-by-case basis. Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of services you receive. This is known as the limiting charge. This means you could be responsible for up to 35% of Medicare's approved amount for covered services instead of 20%. Durable medical equipment (DME) suppliers who are non-participating are not subject to a limiting charge and can therefore charge any amount over the Medicare-approved amount. Non-participating providers must submit claims to Medicare, but Medicare sends payment for 80% of the approved amount to you, not the provider. It is your responsibility to settle accounts with the provider.
- **Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. Medicare will not pay for care you receive from an opt-out provider except in emergencies. These providers can charge whatever they want for services, but they must follow certain rules to do so. An opt-out provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

You can find providers who accept Medicare payment and find out whether they are participating by calling 1-800-MEDICARE or by using Medicare's Physician Compare tool and supplier directory on www.medicare.gov.

If you have a **Medicare Advantage plan,** you may be restricted to using a network of providers in order to pay the least amount for your care. Each type of Medicare Advantage plan has different network rules. A network consists of doctors, hospitals, and medical facilities that contract with a plan to provide services. There are various ways a plan may manage your access to specialists or out-of-network providers. Remember that your costs are typically lowest when you use in-network providers and facilities, regardless of your plan.

Your Medicare Advantage plan is required to cover emergency and urgent care anywhere in the U.S. without imposing additional costs or coverage rules (such as prior authorization). This means that if you seek emergency care from an out-of-network provider, your Medicare Advantage plan must cover the care as if you had gone to an in-network provider. Medicare Advantage plans define an emergency by the prudent person standard. Prudent means acting with care or thought about the future. This standard ensures that even if your condition turns out not to be a medical emergency, it will still be covered as long as a prudent person would have assumed it was an emergency at the time you got care.

It is important to know that not all Medicare Advantage plans—even plans of the same type—work the same way. Make sure you understand a plan's network, cost-sharing, and coverage rules before enrolling. You can

use the Medicare Plan Finder tool available on medicare.gov to compare plan options (https://www.medicare.gov/plan-compare/#/?lang=en). If you have questions, contact the plan for more information.

This table provides a general overview of provider access rules for HMOs, PPOs, and PFFS plans:

	HMO	**PPO**	**PFFS**
Do I need to get a referral before I can see an in-network specialist?	Yes, usually	No	Yes
Will the plan pay for care from a doctor or hospital that is not in the plan's network?	No, unless you need urgent or emergency care or if you have a Point of Service (POS) option that allows you to use out-of-network providers	Yes, but you will pay more, unless it is an emergency	Yes, but you will usually pay more, and the provider must agree to treat you, unless it is an emergency

Note: This chart does not include SNPs or Medicare MSA plans. A SNP is a managed care plan that serves people with special needs. In an MSA plan, you can go to any doctor or hospital willing to accept the plan's payment. If you are considering joining a SNP or an MSA, ask about that specific plan's network rules.

6. What are supplemental benefits?

A supplemental benefit is an item or service covered by a Medicare Advantage plan that is not covered by Original Medicare. These items or services do not need to be provided by Medicare providers or at Medicare-certified facilities. To receive them, you just need to follow your plan's rules. Some commonly offered supplemental benefits are dental care, vision care, hearing aids, and gym memberships. Supplemental benefits must be primarily health-related, with some exceptions for people with chronic conditions. Some supplemental benefits are offered to everyone who is enrolled in a plan, but for an additional premium, such as to add dental coverage. Other benefits may be covered for everyone enrolled in the plan, regardless of whether you use the benefit, such as a gym membership.

Medicare Advantage plans can also cover supplemental benefits that are not primarily health-related for beneficiaries who have chronic illnesses. These benefits should address environmental factors that may affect the health, functioning, quality of life, and risk levels of beneficiaries with chronic conditions. Some examples of these benefits are meal delivery, transportation for non-medical needs, and home air cleaners. Eligibility for this new category of supplemental benefits depends on having a chronic illness.

This means that you:

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

If you meet these criteria, a Medicare Advantage plan **may** offer you one of these new benefits if it has a reasonable expectation of improving or maintaining your health or function. Medicare Advantage plans will be able to create sets of supplemental benefits for people with specific chronic illnesses, which means **not every member of a Medicare Advantage plan will have access to the same set of supplemental 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 may be able to get that service covered, while a member whose asthma is mild may not.

In some cases, there may be no Medicare Advantage plan in your area that covers the supplemental benefits that you need, or you might find that Original Medicare offers better coverage of services that are important to you. You may still be able to access services that Original Medicare does not cover through other insurance or programs.

- **Medigaps:** Medigap policies, insurance that supplements Original Medicare, generally pay second to Medicare when Medicare covers a service and pays first (see #2 above). All Medigaps also offer additional days of inpatient hospital care beyond what is covered by Original Medicare, and some cover emergency medical services received outside of the United States, which are not covered by Original Medicare. Medigaps can also offer fitness benefits or other targeted supplemental coverage in some states.
- **Medicaid:** Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. In some states, Medicaid covers services that are not covered by Medicare, including dental, vision, long-term care, and transportation. A state may also have a Medicaid waiver program that covers additional services, too. To learn more about your state's Medicaid program, contact your local State Health Assistance Program (SHIP). Contact information for your SHIP is on the last page of this document.
- **Reduced-cost or free clinics:** You may be able to access the services you need through a free or reduced-cost clinic in your area. Use resources available at needymeds.org, healthcare.gov, freeclinics.com, and hhs.gov for more information.
- **Donated dental service programs or dental schools:** Donated dental services programs operate in some states. Dentists in these programs offer free dental services if you qualify. You may also be able to get low-cost dental care at a dental school, where dental students work with patients under the supervision of experienced, licensed dentists.

- **Administration for Community Living (ACL) eldercare locator:** Visit eldercare.acl.gov to learn about other resources in your community, such as long-term care and legal aid.
- **Long-term care insurance:** If you anticipate you may need help paying for long-term care in the future, you may decide to purchase long-term care insurance. Long-term care, sometimes referred to as long-term services and support (LTSS) or custodial care, helps you with activities of daily living. Note that companies that offer long-term care insurance are unlikely to sell a policy to you at the time you actually need the long-term care. If you are thinking about purchasing long-term care policy, it is usually best to do so before you think you will need it. Additionally, long-term care policies vary from state to state, so you should contact your SHIP to learn more. Contact information for your SHIP is on the last page of this document.

SHIP Case Study

Donna is turning 65 and becoming eligible for Medicare. She has heard a lot about her options and has seen ads on TV for some plans, but she wants to make an informed decision. She has free, creditable drug coverage through her retiree plan, so she does not want Part D. She sees many providers, and she would like to limit her out-of-pocket costs.

What should Donna do?

- Donna should call her State Health Insurance Program (SHIP) for help comparing her Medicare coverage options.
    - If Donna doesn't know how to contact her SHIP, she can call 877-839-2675 or use the SHIP Locator at www.shiptacenter.org.
- The SHIP counselor can help Donna consider her options, which include getting Original Medicare with or without a Medigap and choosing a Medicare Advantage plan.
    - The SHIP counselor can ask Donna about the providers that she sees, where they practice, and which insurers they accept payment from.
        - If Donna chooses Original Medicare, she will be able to see any provider who accepts Original Medicare payment, anywhere in the country.
        - If Donna chooses a Medicare Advantage plan, she should make sure the providers who she wants to see are in that plan's network and service area. If she sees providers who are not in the plan's network, she will face denials and/or higher out-of-pocket costs. The SHIP counselor can also advise her to learn about a plan's rules related to getting prior authorization or referrals for visits to specialists.
    - Since Donna is trying to limit her out-of-pocket costs, the SHIP counselor can help her understand her options.

        - If she is considering Medicare Advantage plans, she should learn what their deductibles, copays, and coinsurances are. She should also find out about the plans' out-of-pocket limits. She should keep in mind that the cost of non-covered and out-of-network services will not count toward an out-of-pocket limit in an HMO, and out-of-pocket limits are higher for out-of-network services in a PPO.
        - If Donna is considering Original Medicare, the SHIP counselor should also provide her with information about choosing and purchasing a Medigap policy, which has an additional monthly premium but can limit her out-of-pocket costs. The SHIP counselor should also inform Donna about Medigap purchasing rules in her state. Donna has a guaranteed issue right to purchase a Medigap at the best available rate, and cannot be denied coverage, during the first six months she is both 65 and enrolled in Part B. Outside of this period, if Donna does not gave a guaranteed issue right, a Medigap insurer may not sell her a Medigap, or the insurer may charge her a higher premium. Some states have additional enrollment rights.
    - The SHIP counselor can tell Donna about supplemental benefits like dental, vision, and hearing benefits.
        - If Donna is considering a Medicare Advantage plan, she can ask if the plan covers any of these benefits and, if so, what the costs and restrictions related to this coverage are.
        - If Donna would prefer to enroll in Original Medicare, or if there are no Medicare Advantage plans that cover the supplemental benefits she is looking for, the SHIP counselor can provide her with resources about where and how to access these types of services and benefits outside of a Medicare Advantage plan.

SMP Case Study

Maximillian went to a health fair at his local senior center, and, because he is turning 65 soon, he spoke to a representative from a Medicare Advantage plan. This representative told him that if he signs up for that plan, he will qualify for benefits like home-delivered meals, non-medical transportation, and pest control in his home. Maximillian hadn't heard about benefits like this before and wants to double check that the representative was correct before he makes any decisions.

What should Maximillian do?

- Maximillian should call his Senior Medicare Patrol (SMP) for assistance
    - If he doesn't know how to reach his SMP, he can call 877-808-2468 or visit www.smpresource.org

- The SMP can tell Maximillian that he was correct to be concerned about what the plan representative told him. They can let him know that some Medicare Advantage plans can offer supplemental benefits like home-delivered meals, non-medical transportation, and pest control, but that they must be offered to beneficiaries with chronic conditions. If this representative didn't have information about Maximillian's medical conditions, he shouldn't have claimed that Maximillian would definitely qualify for them.
    - The SMP can tell Maximillian that this plan representative might have been engaging in misleading marketing by providing this incomplete or inaccurate information. If Maximillian wants, they can help him report it to the proper authorities.
- Since Maximillian will be eligible for Medicare soon, the SMP can also tell him about resources to learn more about Medicare options.
    - The SMP can direct him to the SHIP for counseling on enrolling in Medicare, choosing between Original Medicare and Medicare Advantage, and enrolling in Part D prescription drug coverage and supplemental coverage.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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