



## **Making Informed Decisions: Navigating Medicare Advantage**



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# Table of Contents

Introduction . . . . .	3
Types of Medicare Advantage Plans . . . . .	4
Questions to Ask When Considering MA Plans	
PPO . . . . .	6
HMO . . . . .	12
PFFS . . . . .	18
SNP . . . . .	25
Disenrollment Information . . . . .	31
Resource Information . . . . .	32

*This page added by the South Dakota SMP*

# Making Informed Decisions: Navigating Medicare Advantage

## Introduction

Medicare beneficiaries have the option of receiving their Medicare benefits through the Original Medicare program, also known as fee-for-service Medicare, or through a Medicare Advantage (MA) plan, sometimes called a Medicare Health Plan. MA plans are private plans that are available to all people with Medicare. MA plans may lower your health care costs and may provide benefits above and beyond those offered by Original Medicare.

This booklet is for people with Medicare who are considering joining a Medicare Advantage plan. It describes the different types of Medicare Advantage plans, and provides a list of questions for you ask the plan BEFORE you make a decision. Asking informed questions will help you make an informed decision. As you navigate the many choices you face, the ultimate question should be "What coverage is right for ME?" This brochure has been created to help you make a decision that is right for you.

**Original Medicare plus Medigap:** Original Medicare is a cost sharing system between the Medicare program and you (the beneficiary). Medigap policies are private insurance plans that supplement Original Medicare by paying the portion of medical costs that are not covered by Original Medicare. For example, Original Medicare only pays 80% of the cost of a doctor visit; you must pay the remaining 20%. If you have a Medigap plan, it pays that 20%. You pay a monthly premium for a Medigap plan. There are twelve standard plans, known by the letters A through L, that provide different benefits. If you have Original Medicare and a Medigap plan, you can see any provider or go to any hospital that accepts Medicare.

**Medicare Advantage (MA) plans:** These plans are managed care plans within the Medicare program. They cover all the services covered by Original Medicare. If you join an MA plan, you must follow their rules about getting care. For example, there may be limitations on the providers that you can see, and you may be required to get referrals to see specialists. If you are in an MA plan and do not follow their rules, you may be responsible for the entire cost of care. Once you enroll in an MA plan, your Medicare benefits will come only from that plan. In addition, there are restrictions on when you can disenroll from an MA plan and join another MA plan. MA plans are not all the same. There are many choices within the different types of plans. The types of MA plans are described in this booklet, along with questions to help you guide your decision.

## A. Types of Medicare Advantage Plans

### 1. Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs)

PPOs and HMOs are both types of coordinated care plans. Generally, in an HMO, you must seek all services from a designated network of providers and may need prior authorization from the HMO or from your primary care physician in order to obtain certain services. If you go out of network for care, there will be no coverage unless care was urgent or sought due to an emergency. In contrast, PPOs generally allow out of network care, but charge higher co-payments for services received out-of-network.

- [Please turn to p. 6 to see the counseling guide for PPOs.](#)
- [Please turn to p. 12 to see the counseling guide for HMOs.](#)

### 2. Private Fee-for-Service (PFFS) Plans

PFFS plans cover all Medicare-covered care (as do all MA plans) but the plan is not required to secure a network of providers willing to accept the PFFS insurance option. You must check with your providers and local hospitals to see if they will accept a particular PFFS plan – providers vary widely in whether they are willing to accept PFFS plans.

- [Please turn to p. 18 to see the counseling guide for PFFS plans.](#)

### 3. Special Needs Plans (SNPs)

SNPs generally are coordinated care plans. They may substantially limit enrollment to three Medicare populations (and tend to target these populations in the services provided): (a) institutionalized beneficiaries; (b) beneficiaries who have both Medicare and Medicaid; and (c) beneficiaries diagnosed with certain chronic and disabling disease conditions. If you have Medicare and Medicaid (also known as “dually eligible”) check with your State Medicaid office to make sure the SNP has a contract with Medicaid to cover premiums and co-pays.

- [Please turn to p. 25 to see the counseling guide for SNP plans.](#)

#### 4. Medicare Savings Accounts (MSAs)

MSAs combine a special savings account into which Medicare deposits an amount of money each year with a high deductible MSA plan. The deductible amount may, or may not, be fully covered by the amount Medicare deposits into the savings account.

Please note that enrollment in MSAs is limited to the Annual Enrollment Period (AEP), which occurs every year from November 15 through December 31. Counseling questions about MSAs are not included in this brochure.

#### B. Other Options

There are additional options available to some people with Medicare (see below). This booklet does not provide information on these options. Your local SHIP program is always a resource for more information.

- **Retiree Health Benefits:** You may be able to get additional coverage from your own or your spouse's former employer to help fill in some of the gaps. To learn about these options, contact the Benefits Coordinator at your former employer. If you have retiree coverage, be sure talk to a SHIP counselor or your former employer to find out how enrollment in an MA plan can impact your retirement coverage.
- **Assistance for those with lower incomes:** Some people have a lot of trouble paying for health care or health insurance. Fortunately, there are some programs to help those with limited incomes, including Medicaid, Medicare Savings Programs, and the Low-Income Subsidy for Medicare Part D. Contact your local SHIP office or your state Medicaid office for more information.

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

Medicare PPOs are one of the Medicare Advantage program's coordinated care plans. They agree to provide all the Medicare-covered benefits a person would receive under Medicare Parts A and B, and sometimes cover additional benefits. PPOs receive a monthly payment from Medicare for each person who enrolls. Some charge enrollees an additional monthly premium. People who join PPOs can save money by receiving services from doctors, hospitals, and others who belong to the PPO's "preferred provider" network. PPO plan members can go to other health care providers who do not belong to the PPO's provider network, but it will usually cost more. PPO plans work like Health Maintenance Organizations (HMOs) in many ways, with one big difference. PPOs allow you to go to out-of-network doctors and specialists without needing referrals or prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

**Notes:** \_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

**Notes:** \_\_\_\_\_  
\_\_\_\_\_

The plan's annual cap for in-network services is: \_\_\_\_\_

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

5. Are you prepared to cover the PPO's co-payments for hospital stays?

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

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

**Notes:**

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

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

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

**Notes:**

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

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

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

**Notes:** \_\_\_\_\_  
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8. Which covered benefits have a fixed co-payment? Which have coinsurance charges, that is, a percent of the total cost of an item or service? Does the PPO use a coinsurance to calculate your share of the cost for medical equipment, supplies, and Part B drugs, such as chemotherapy medications? Are you prepared to cover the coinsurance charges for expensive services or items?

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

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

**Notes:** \_\_\_\_\_  
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9. Are you enrolled in your state's Medicaid program or the Qualified Medicare Beneficiary (QMB) program?

In some states, the Medicaid program does not work with Medicare PPOs to cover plan co-payments and other out-of-pocket costs. Instead, Medicaid works with Original Medicare. Your Medicaid benefits could be worthless if you join a PPO.

**Action step:** Call the PPO to find out how they work with Medicaid.

**Notes:**  
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## Medicare Advantage: Questions to Ask Medicare Health Maintenance Organization (HMO)

Medicare HMOs are one of the Medicare Advantage program's coordinated care plans. They agree to provide all the Medicare-covered benefits a person would receive under Medicare Parts A and B, and sometimes cover additional benefits. HMOs receive a monthly payment from Medicare for each person who enrolls. Some charge enrollees an additional monthly premium. People who join HMOs usually must receive services from doctors, hospitals, and others who belong to the HMO's provider network. A primary care physician or physician assistant coordinates the care enrollees receive. HMOs often require these "gatekeepers" to seek approval from the plan before the HMOs pay for visits to specialists. By using network providers and following the HMO's rules for prior approval and referrals, plan members often have reduced costs for covered services. The HMO generally will not pay for out-of-plan services except in emergencies or urgent situations.

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

**About Access to Care in (name of HMO):** \_\_\_\_\_

1. How important is it for you to go to any doctor you choose? How important is it for you to see your current doctor(s)? Do they belong to the HMO's provider network? Do you often see specialists?

In Original Medicare, you can go to any doctor or hospital in the country that accepts new Medicare patients. In a Medicare HMO, you will be limited in most cases to using the primary care physicians and specialists in the HMO's network. If you see a provider outside of the network, you will have to pay the full amount for that care, except in emergencies and urgent care situations.

**Action step:** Call your doctors to ask if they belong to the HMO's provider network.

**Notes:** \_\_\_\_\_

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

Medicare HMOs need not include all of the hospitals in your community in their provider networks. If you go to hospital that is not in the network, the HMO may not pay for the services you receive. You could owe the entire bill. Original Medicare will pay for care at nearly all hospitals in the U.S.

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

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

To enroll in a Medicare HMO, you must live in the plan's service area for most of the year. If you need non-urgent care while you vacation or spend a season outside the service area, a Medicare HMO may not pay for the care you need. Original Medicare covers you in all fifty states, the District of Columbia, and the U.S. Territories.

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

**Notes:** \_\_\_\_\_  
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4. What rules does the plan use to approve costly tests, specialty care, and surgery? Are you comfortable with these rules and the limits they may place on your access to some providers and services?

HMOs often require your doctors to ask the plan to approve diagnostic and surgical procedures. Without prior approval, the HMO will not pay for the services. Sometimes HMOs do not approve a procedure or course of treatment that doctors recommend, even when there is a medical need for it. HMOs contain costs through these prior approval rules. Original Medicare pays for medically necessary services without prior approval rules.

**Action step:** Ask the HMO to describe how its prior approval process works, and to give some examples of the kinds of medical services that are subject to prior approval.

**Notes:** \_\_\_\_\_  
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5. Does the HMO have a cap on annual out-of-pocket spending? Does it have separate caps for medical and prescription drug coverage? Are you prepared financially to cover out-of-pocket costs up to the cap (or beyond)?

A reasonable out-of-pocket limit is about \$2,500 to \$3,000. This is the amount you would spend for the year. Note that some Medicare HMOs do not have caps on your annual spending. In some medical situations, you could owe many thousands of dollars in combined co-payment and coinsurance charges.

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

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The plan's annual out-of-pocket limit is:** \_\_\_\_\_

6. Are you prepared to cover the HMO's co-payments for hospital stays?

Co-payments of \$150 to \$200 per day for the first five days--or more--of a hospital stay are common. Ten days in a hospital could cost in excess of \$1,500. Original Medicare's annual deductible for hospital stays is \$1,068 (2009). Most supplement insurance policies cover the cost in Original Medicare, but not for an HMO.

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

**Notes:** \_\_\_\_\_  
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7. What are the co-payments for Skilled Nursing Facility (SNF) care and Home Health care? Do the costs count toward the annual out-of-pocket limit?

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

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

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8. What are the HMO's co-payments for outpatient surgery and other outpatient medical procedures? Do these costs count toward the annual out-of-pocket limit? Are you prepared to cover the out-of-pocket costs for multiple hospitalizations, physical therapy treatments, and ambulance trips?

Many surgical, medical, and rehabilitation procedures routinely occur in an outpatient setting. Co-payments for each outpatient service are \$150 or more at some HMOs. The co-payments for a series of outpatient visits, as physical therapy after a stroke, can quickly add up to thousands of dollars. Also, some HMOs do not count the co-payments for services like ambulatory surgery toward the annual cost-sharing limit.

**Action step:** Ask the HMO about co-payments for outpatient hospital services, including day surgery and rehabilitation. Ask about the services that do not count toward the limit.

**Notes:** \_\_\_\_\_  
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9. Which covered benefits have a fixed co-payment? Which have coinsurance charges, that is, a percent of the total cost of an item or service? Does the HMO use a coinsurance to calculate your share of the cost for medical equipment, supplies, and Part B drugs, such as chemotherapy medications? Are you prepared to cover the coinsurance charges for expensive services or items?

Some HMOs apply a coinsurance charge, often 20 percent, to durable medical equipment (such as wheelchairs and oxygen equipment), medical supplies, prosthetics, and some drugs. These include chemotherapy and other drugs involved in cancer treatment. The coinsurance charges for chemotherapy drugs can be very high. With chemotherapy costing as much as \$100,000, your 20 percent share of the cost would be \$20,000 (if the plan has no annual cap on out-of-pocket costs).

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

**Notes:** \_\_\_\_\_  
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10. Are you enrolled in your state’s Medicaid program or the Qualified Medicare Beneficiary (QMB) program?

In some states, the Medicaid program does not work with Medicare HMOs to cover plan co-payments and other out-of-pocket costs. Instead, Medicaid works with Original Medicare. Your Medicaid benefits could be worthless if you join an HMO.

**Action step:** Call Medicaid to ask how it works with Medicare HMOs.

**Notes:** \_\_\_\_\_  
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## Medicare Advantage: Questions to Ask Medicare Private-Fee-for-Service (PFFS) Plans

Medicare PFFS plans are one type of Medicare Advantage program option. Private insurance companies offer PFFS plans under contract with Medicare. Like other types of Medicare Advantage plans, PFFS plans must cover the same Medicare benefits that a person would receive under Medicare Parts A and B. Some plans may cover additional benefits, such as routine dental and vision care. PFFS plans receive a monthly payment from Medicare for each person who enrolls, though many charge an additional monthly premium. The PFFS plans, not Medicare, set payment rates for doctors, hospitals and other providers. Their payments may be lower than Medicare's standard "approved amounts."

People who join a PFFS plan can go to any Medicare-approved doctor or hospital that is willing to accept the plan's payment terms and conditions. **People who join a PFFS plan must be prepared to ask all their health care providers, before receiving services, if they are willing to accept the plan's payment terms. Not all health care providers accept payments from PFFS plans.** If the provider accepts the terms, the PFFS plan pays a fee for each service. Keep in mind that doctors can decide at each visit whether or not to accept the plan's terms and whether or not to treat a patient (except for emergencies).

**About Access to Care in (name of PFFS):** \_\_\_\_\_

1. How important is it for you to be sure that your physicians, including specialists, will provide services to you and accept insurance payments on your behalf?

In Original Medicare, you can go to any doctor who accepts new Medicare patients. The vast majority of physicians in the United States accept payments from the Original Medicare program (Medicare Part B) with no questions asked. Also, Medicare coordinated care plans like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) have networks of doctors who agree to serve anyone who is enrolled in the HMO or PPO plan. With both Original Medicare and Medicare's coordinated care plans, there is little guesswork involved in finding a doctor who accepts the payment terms.

**Action step:** Before enrolling in a PFFS plan, ask your doctors if they accept the PFFS plan's terms and conditions of payment. If you spend part of the year living in another locale and have doctors there, make sure to call and ask them too. **NOTE:** You must also check with local hospitals and other places where you go for health care to see if they accept the PFFS plan's payments as well. See number two below.

**Notes:** \_\_\_\_\_

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2. How important is it for you to be sure that hospitals, skilled nursing facilities, and home health agencies will provide you services and accept payments on your behalf?

All hospitals, skilled nursing facilities, and home health agency that receive payments from the Original Medicare program (Medicare Part A)—to the extent that they are equipped to do so—must serve Medicare patients and accept payments directly from Medicare on their behalf. With PFFS plans, you can't be sure. Health care providers, including hospitals and home health agencies, are not required to accept payments from PFFS plans. They also have the option to accept payment in one case, and not in another.

**Action step:** Before enrolling in a PFFS, ask your local hospital and at least one nearby Medicare-certified skilled nursing facility and home health agency if they accept the PFFS plan's terms and conditions of payment. If you spend part of the year living in another locale, make sure to call the hospital and other providers there too.

**Notes:** \_\_\_\_\_

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3. How important is it for you to be sure that medical equipment suppliers, physical therapists, psychologists, and other health care providers will provide you services and accept payments on your behalf?

With Original Medicare, there is rarely a question about whether a medical equipment supplier or other health services provider will accept the terms of terms and conditions of payment under Medicare Part B. Similarly, with Medicare's coordinated care plans, you know what to expect because HMOs and PPOs must publish the names of suppliers and others in provider network directories. With PFFS plans, you can't be sure without asking all service providers if they are willing to accept the plan's terms of payment.

**Action step:** Before enrolling in a PFFS plan, ask at least one local Durable Medical Equipment supplier if they accept payments from PFFS plans. If you are currently using Medicare-covered equipment and supplies (oxygen and infusion therapy systems, for example), call your supplier to make absolutely sure that you know if enrolling in a PFFS plan will disrupt your care.

**Notes:** \_\_\_\_\_

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4. What rules does the plan have to pre-approve hospital admissions, outpatient surgery, and other costly services? Are you comfortable with these rules and the limits they may place on your access to some services?

Original Medicare pays for medically necessary services without prior approval rules. Some PFFS plans require you to call them before you receive some services and procedures, including day surgery procedures. Without prior approval, the plan may not pay for the services. Some charge a penalty for failing to notify the plan of an upcoming hospital admission.

**Action step:** Call the PFFS plan to ask how its prior approval process works and to tell you which medical services are subject to the procedure.

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5. Are you prepared to cover the PFFS plan's co-payments for inpatient hospitalization, skilled nursing facility stays, and home health care visits?

Co-payments for each inpatient hospital stay vary a lot among different PFFS plans. Some plans have no co-payment for hospitalizations. Others may charge several hundred dollars for each hospital stay. Some PFFS plans also only cover a portion of home health nursing and physical therapy visits.

Original Medicare's deductible for hospital stays is \$1,068 (2009) per benefit period. Most supplement insurance (Medigap) policies cover the inpatient deductible in Original Medicare. These Medigap policies **cannot** cover out-of-pocket costs in any Medicare Advantage plan, including PFFS plans. In a PFFS plan, you must be prepared to cover any and all co-pays on your own. Note also that there is no co-pay for home health care in Original Medicare. Medicare Part A covers 100 percent of the cost for medically necessary nursing and rehabilitation home visits.

**Action step:** Check the PFFS plan's total, annual out-of-pocket costs for one or more inpatient hospital stays. Ask how much your cost would be for three home health nursing visits or physical therapy visits.

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6. Which covered benefits have a fixed co-payment? Which charge a coinsurance (that is, a percent of the total cost of an item or service) for services? Does the PFFS plan use a coinsurance charge to calculate your share of the cost for medical equipment, supplies, and Part B drugs, such as chemotherapy medications? Are you prepared to pay the coinsurance charges for expensive services or items?

Some PFFS plans use a coinsurance charge, typically 20 or 30 percent, for durable medical equipment (e.g., wheelchairs and oxygen equipment), medical supplies (e.g., diabetes supplies), prosthetics, and some drugs such as chemotherapy drugs and drugs used to treat anemia. The coinsurance charges for chemotherapy drugs can be very high. If chemotherapy costs \$100,000, your 20 percent share of the cost would be \$20,000 (if the plan has no annual cap on these out-of-pocket costs). Original Medicare and a Medigap insurance policy would cover the entire cost of these drugs. Medigap insurance does not work with PFFS plans to cover these coinsurance charges.

**Action step:** If you use medical equipment like wheelchairs, hospital beds, or oxygen tanks, ask the PFFS plan what you would owe in monthly coinsurance charges. You could also ask what your estimated out-of-pocket cost would be for expensive Part B drugs.

**Notes:** \_\_\_\_\_

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7. Can doctors, hospitals, and other care providers bill you for the difference between the plan’s payment and the provider’s actual bill?

PFFS plans may allow doctors and other health care providers to bill you for part of the balance between the plan’s payment rate and the provider’s actual bill. The balance billing limit is fifteen percent of the plan’s payment rate. If, for example, the plan’s payment rate is \$100 for a service that actually costs \$150, you might owe a \$25 co-payment (your share of the \$100 rate) plus fifteen percent of the \$100, or \$15, for a total of \$40 out-of-pocket. You must keep in mind that that fifteen percent of a hospital bill can add up to a very large sum.

Original Medicare does not permit hospitals, skilled nursing facilities, home health agencies, or ambulance companies to balance bill. It does, however, permit physicians to collect up to 15 percent of Medicare's approved amount on the balance of a doctor's bill. Physicians who collect the higher charge are said not to "accept assignment." In recent years, physicians in Original Medicare accepted assignment, meaning they did not charge an additional 15 percent above Medicare's approved amount, 99 percent of the time. They took Medicare's approved amount as payment-in-full. Medicare publishes a list of physicians who always accept assignment in Original Medicare. They are called "Participating Physicians." Go to [www.medicare.gov](http://www.medicare.gov) and click on "Find a Doctor." People with Original Medicare and a Medigap policy have no out-of-pocket costs or balance billing when doctors accept assignment. Those without a Medigap policy pay the 20 percent co-insurance under Original Medicare.

**Action step:** Ask the PFFS plan about which health care providers can "balance bill." Does the list include hospitals, skilled nursing facilities, medical equipment suppliers, and ambulance companies?

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8. Does the PFFS plan have a cap on annual out-of-pocket spending? Does it have separate caps for medical and prescription drug coverage? Are you prepared financially to cover out-of-pocket costs up to the cap (or beyond)?

Most PFFS plans expect you to pay an out-of-pocket amount for services such as inpatient hospital stays, doctor visits, and outpatient care. In some medical situations, you could owe many thousands of dollars in combined co-payment and coinsurance charges. Annual limits place a cap on your out-of-pocket spending. After you reach the limit, the plan pays 100 percent of the cost for your ongoing care. A reasonable out-of-pocket limit is about \$2,500 to \$3,000. This is the amount you would spend for the year. Some PFFS plans have annual spending caps of \$4,000 or more, and some have no caps at all. Others have separate caps on total inpatient hospital co-payments.

**Action step:** Ask the PFFS plan to explain which services apply to the annual limit on out-of-pocket spending. Do balance billing amounts (see number seven above) count toward the cap?

**Notes:** \_\_\_\_\_

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

Unlike most other Medicare Advantage plans, PFFS plans are not required to offer prescription drug coverage under Medicare Part D. Some PFFS plans offer Part D drug coverage. Others do not. If a PFFS plan does not cover prescription drugs, you can enroll in a stand-alone prescription drug plan sponsored by a different insurance plan. Note that co-payments for prescription drugs usually do not count toward a PFFS plan's annual cap on out-of-pocket costs for other medical services and supplies (see number eight above).

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

**Notes:** \_\_\_\_\_

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**Remember:** You have the right to have your questions answered. You can take home a PFFS plan's application and other information materials and think about it. Before enrolling in any Medicare Advantage product, including PFFS plans, weigh your health coverage options and costs carefully. Talk to people you trust, including counselors at your state's SHIP program, who have nothing to gain from your enrollment decision. Because all Medicare Advantage products change how you receive your health care benefits through Medicare, do not rush to a decision or sign anything under pressure.

## Medicare Advantage: Questions to Ask Medicare Special Needs Plans (SNPs)

Medicare SNPs are one of the Medicare Advantage program's coordinated care plans. They agree to provide all the Medicare-covered benefits a person would receive under Medicare Parts A and B, and may choose to cover additional benefits. The main difference between SNPs and other types of coordinated care plans is that SNPs are allowed to limit enrollment to people with specific health or financial needs. There are three types of Special Needs Plans:

1. SNPs for people with Medicare and full Medicaid,
2. SNPs for people in institutions (including nursing homes), and
3. SNPs for people with certain chronic conditions.

Since Special Needs Plans are coordinated care plans, they may be designed like a Preferred Provider Organization (PPO) or like a Health Maintenance Organization (HMO). For example, a company can offer an HMO SNP for people in institutions. The same company can offer a PPO SNP for people with Medicare and Medicaid.

While Medicare SNPs may work well for many people, they are not for everyone. Because HMOs and PPOs have different rules about provider networks, referrals, and prior approval, it is important to understand what type of Special Needs Plan you are considering. Also, there are different questions to ask depending on which population the Special Needs Plan serves. Keep in mind that a Special Enrollment Period exists that allows people to join or leave SNPs throughout the plan year, so you can enroll in or disenroll from a Special Needs Plan at any time.

Take some time to get answers to the questions below. Use the space provided to jot down the names of plan contacts and the answers they give. To understand more about how Health Maintenance Organizations and Preferred Provider Organizations work, ask your SHIP counselor for the Making Informed Decisions tools on HMOs and PPOs.

**About Access to Care in (name of SNP):** \_\_\_\_\_

1. Is this Special Needs Plan an HMO or a PPO? \_\_\_\_\_

Note: Use the *Making Informed Decisions* tools on HMOs and PPOs to ask other important questions of the HMO SNP or PPO SNP you are considering.

2. Who can join this Special Needs Plan?

Those with Medicare and full Medicaid (dual eligibles) Go to Question 3.

Those in institutions (including nursing homes) Go to Question 7.

Those with certain chronic conditions

(name of the disease or condition: \_\_\_\_\_) Go to Question 10.

### SNPs for Dual Eligible Beneficiaries

3. Does the SNP contract with your state's Medicaid program?

Yes

No

4. Does the plan have a payment arrangement with Medicaid so that you do not have to pay out-of-pocket costs?

Yes

No

If you have original Medicare and Medicaid, your out-of-pocket costs should be minimal. Your doctors work directly with Medicare and Medicaid so that you do not have to be reimbursed for your care. While some SNPs contract with your state's Medicaid program, some may not. If the SNP does not have a contract, you might be required to pay for services out-of-pocket and then ask Medicaid to pay you back.

**Action step:** Call your state's Medicaid office to see if the SNP has payment arrangements or a contract with Medicaid.

**Notes:**

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5. Does the SNP offer services that are not covered by Medicare or Medicaid?

SNPs, including ones for dual eligible beneficiaries, are permitted to offer extra coverage (like vision and dental care) to their members. Sometimes this extra coverage is already covered by state Medicaid programs. It is important to know which of these services are actual extra benefits and which are not, so that you can decide if a SNP is the right choice for you.

**Action step:** Ask the SNP what extra health services their plan covers that are not covered by Medicare and Medicaid. You may also want to double-check coverage with your Medicaid caseworker.

**Notes:**

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6. Does the SNP provide care coordination or assistance with navigating both the Medicare and Medicaid systems?

Because dual eligible beneficiaries have health coverage from two sources, it is important to understand how the programs work together. Original Medicare and Medicaid do not provide care coordination or other services to help beneficiaries use their health coverage in more effective ways. Some SNPs offer services that help coordinate patients' care, navigate Medicare and Medicaid, and work more effectively with doctors.

**Action step:** Ask the SNP if it provides these types of services.

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## SNPs for Beneficiaries in Institutions

7. Does the SNP contract with the institution in which you reside?

SNPs are required to have a contract with facilities before accepting the enrollment of any facility residents into the Special Needs Plan.

**Action step:** Ask the SNP if it contracts with the facility.

**Notes:**

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8. What are the benefits of the SNP compared to your current coverage? How is this SNP different than a SNP for dual eligibles?

Institutional SNPs are permitted to offer extra benefits to their members. Sometimes these extra benefits are already covered by your current health insurance, especially if you have Medicaid. It is important to know which of these benefits are actual extra benefits and which are not, so that you can decide if a SNP is the right choice for you.

Some extra benefits that may be offered include:

- Transportation to a hospital
- Geriatric nurse practitioners in the facilities
- Home health services, for those in the community
- Respite for caregivers, for those in the community
- Homemaker assistance, for those in the community
- Transportation to appointments, for those in the community

**Action step:** Ask the SNP what extra benefits the plan covers. Ask the plan if it covers disease management programs or care coordination services. You may also want to ask if it offers services to help enrollees avoid hospitalization (if you live in a nursing facility) or institutionalization (if you live in the community).

**Notes:**

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9. If you also have Medicaid, it is important to know if the SNP contracts with your state's Medicaid program. If not, does the plan have a payment arrangement with Medicaid so that you do not have to pay out-of-pocket costs?

If you have original Medicare and Medicaid and live in a nursing facility, your out-of-pocket costs should be minimal. Your facility works directly with Medicare and Medicaid so that you do not have to pay out-of-pocket. While some SNPs contract with your state's Medicaid program, some may not. If your SNP does not have a contract, you might be required to pay for services out-of-pocket and ask Medicaid to pay you back.

**Action step:** Call your state's Medicaid office to see if the SNP has payment arrangements or a contract with Medicaid.

**Notes:**

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### SNPs for Chronic Conditions

10. Does the SNP make it easier for people with your condition to get certain needed health services or prescription drugs?

Some SNPs for people with chronic conditions offer specialized access to health services or prescription drugs. They might have fewer restrictions on seeing specialists or have a bigger network of certain types of specialists. Some SNPs have fewer restrictions on classes of drugs for a chronic condition. For example, they may not have prior authorization requirements on drugs that people with your condition use frequently.

**Action step:** Ask the SNP about how their coverage is tailored to make it easier for you to get health services or prescription drugs.

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11. Does the SNP offer extra benefits that are not covered by your current coverage?

SNPs, including ones for beneficiaries with chronic conditions, are permitted to offer extra benefits (like vision and dental care) to their members. SNPs for chronic conditions may provide benefits that aim to help you avoid hospitalization or better manage your condition. Sometimes these extra benefits are already covered by your current health insurance, especially if you have Medicaid. It is important to know which of these benefits are actual extra benefits and which are not, so that you can decide if a SNP is the right choice for you.

**Action step:** Ask the SNP what extra health benefits their plan covers. Ask the plan if it covers disease management programs or care coordination services.

**Notes:**

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12. If you also have Medicaid, it is important to know if the SNP contracts with your state's Medicaid program. If not, does the plan have a payment arrangement with Medicaid so that you do not have to pay out-of-pocket costs?

If you have original Medicare and Medicaid, your out-of-pocket costs should be minimal. Your doctors work directly with Medicare and Medicaid so that you do not have to be reimbursed for your care. While some SNPs contract with your state's Medicaid program, some may not. If your SNP does not have a contract, you might be required to pay for services out-of-pocket and ask Medicaid to pay you back.

**Action step:** Call your state's Medicaid office to see if the SNP has payment arrangements or a contract with Medicaid.

**Notes:**

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## Disenrollment from a Medicare Advantage Plan

Disenrolling from a Medicare Advantage Plan **may** be an option for you. You will want to take your time and research your options **before** you make this important decision.

First, you must fit into one of the election periods listed below.

- Annual Election Period (AEP)
- Initial Election Coverage Period (IECP)
- Special Election Period (SEP)
- Open Enrollment Period (OEP)

Disenrolling outside of these election periods may result in a loss of benefits and have financial consequences. Take your time and do your research before taking this step.

To find out more about the election periods refer to your Medicare Handbook or call 1-800-Medicare (1-800-633-4227) to speak with a Customer Service Representative. You can also find disenrollment information listed in your Medicare Advantage Plan's "Evidence of Coverage Booklet".

*This page added by the South Dakota SMP*

## Medicare Advantage: Cost Counts But...

The majority of people with Medicare have moderate incomes. Because costs are so important, people often look at premiums first. Here are some other considerations:

- Cost Sharing vs. Premiums: Original Medicare has a standard cost sharing structure (80% of costs covered by Medicare and 20% paid by you). Medigap plans can be used to pay your additional costs, including deductibles. MA plans set their own cost sharing structures so while they may have *lower premiums* you may end up *paying more* in costs for services.
- Paying more does not always mean getting more. Some policies that cost less can cover more services.

## Don't just look at the premium! Compare your options to see:

- How cost sharing is structured.
- Does the MA plan come with a prescription drug plan or will you have to buy a Part D plan? Are your drugs covered by the MA Part D plan?
- Can you use any doctor or hospital? Do you need to get approval ahead of time to see a specialist, get a lab test, or go to the hospital or nursing home? Are the facilities convenient for you and your family?

## Medicare Advantage: Find Out More

- Find your local SHIP at <http://www.hapnetwork.org/ship-locator>.
- Contact your local SHIP: 1-800-536-8197 website: [www.shiine.net](http://www.shiine.net)
- Call 1-800-MEDICARE (1-800-633-4227), a toll-free number available 24 hours a day, 7 days a week or use the official Medicare website: [www.medicare.gov](http://www.medicare.gov).
- Report suspected Fraud or Marketing Abuse to the **South Dakota SMP** at: 1-800-822-8804 or 1-800-695-8168 website: [www.SouthDakotaSMP.org](http://www.SouthDakotaSMP.org)
- For additional copies of the Counseling Guides:  
PPO: <http://www.hapnetwork.org/assets/docs/ma-tools/ppo-counseling-questions.doc>  
HMO: <http://www.hapnetwork.org/assets/docs/ma-tools/hmo-counseling-questions-1.doc>  
PFFS: <http://www.hapnetwork.org/assets/docs/ma-tools/pffs-counseling-questions.doc>  
SNP: <http://www.hapnetwork.org/assets/docs/ma-tools/snp-counseling-questions.doc>

**Talk to the plans that you are interested in, use this guide to ask questions, and don't rush into a decision. Remember, this is your health care and you have the right to be informed!**