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MEDICARE ADVANTAGE

Se habla español

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WHAT IS MEDICARE ADVANTAGE?

In addition to the government's traditional Medicare program, Medicare offers individuals the option to receive services through a variety of private insurance plans. These private insurance options are part of Medicare Part C and are called Medicare Advantage (MA) plans. MA is a means of receiving health care and Medicare coverage. An individual who joins an MA plan is still in the Medicare program. To participate in Medicare Advantage an individual must specifically opt to receive Medicare coverage through an MA plan. Once this choice is made, the individual must generally receive all of his or her care through the plan's providers in order to receive Medicare coverage. One of the main goals of MA plans is to manage health care in order to reduce costs while also providing necessary care.

An MA plan must provide or pay for medically necessary Part A and Part B covered items and services. Traditional Medicare will pay the hospice for services received by an enrollee who elects hospice while enrolled in the MA plan. In addition to providing traditional Medicare benefits, the MA plan may also provide and pay for supplemental benefits (benefits not covered under Part A or Part B) and prescription drug benefits. Many MA plans also include Part D prescription drug coverage. These plans are known as Medicare Advantage Prescription Drug plans or MA-PDs.

MA plans differ with respect to what benefits they provide, out-of-pocket costs such as premiums, deductibles, and co-pays, and whether they provide prescription drug coverage. It is important to remember that individuals do not have to change the way they currently access their Medicare benefits, whether they are in traditional Medicare or an MA plan. An individual with coverage through their current or former employer should check to see how any changes might affect such coverage.

MEDICARE ADVANTAGE ENROLLMENT PERIODS

An individual is only permitted to join or leave an MA plan at certain times during the year. This is referred to as the “lock-in” rule. There are several election periods during which an enrollment request can be made.

The **Initial Coverage Election Period (ICEP)**, the period during which a newly MA eligible individual may make their initial choice to enroll in an MA plan. This period begins three months immediately before the individual’s first entitlement to both Medicare Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B, or, the last day of the individual’s Part B initial enrollment period.

During the **Annual Coordinated Election Period (ACEP)** all MA eligible individuals may elect among all available options, whether traditional Medicare, MA plans, MA-PD plans, or Prescription Drug Plans (PDPs). The ACEP occurs from October 15 through December 7 of every year; coverage begins on the first day of the following calendar year. The Annual Enrollment Period for Part D mirrors that of the ACEP for MA.

Open Enrollment Period for Institutionalized Individuals (OEPI). MA eligible individuals, who move into, reside in, or move out of a nursing home or other institution, as defined by the Centers for Medicare & Medicaid Services (CMS), can make an unlimited number of MA elections.

The **Medicare Advantage Disenrollment Period (MADP)** gives an MA plan enrollee the opportunity to disenroll from any MA plan and return to traditional Medicare between January 1 and February 14 of every year. Disenrollment is effective the first of the following month. The MADP does not provide an opportunity to join or switch MA plans, but it does allow someone leaving an MA plan to pick up Part D prescription drug coverage.

ENROLLMENT PERIODS (Cont.)

During a **Special Enrollment Period (SEP)** an individual may elect a plan or change their current plan election. There are many different SEPs, including: for individuals whose current plan terminates, violates a provision of its contract, or misrepresents the plan's provisions; individuals who change residence; and individuals who meet "exceptional circumstances" as the Medicare program may provide.

CMS has designated an SEP for those individuals who are eligible for Medicare and full Medicaid (dual eligibles) and for those eligible for "Medicare Savings Programs". These individuals can make an MA change or return to traditional Medicare at any time.

MA eligible individuals who elect an MA plan during the initial enrollment period surrounding their 65th birthday have an SEP, known as SEP65. SEP65 allows the individual to disenroll from an MA plan and elect traditional Medicare any time during the 12-month period that begins on the effective date of coverage in the MA plan.

An eligible individual may enroll in an MA plan with a plan performance rating of 5 stars during the year in which that plan has the 5-star overall rating. Eligible individuals can switch from an MA plan, a PDP, or traditional Medicare to an MA-only plan, an MA-PD plan, or a PDP that has a 5-star overall rating. Individuals enrolled in plans with fewer than 3 stars for 3 consecutive years will be given the opportunity to contact CMS via 1-800-MEDICARE to request a SEP to move into a higher quality plan beginning in 2013.

HOW AND WHEN TO DISENROLL FROM A MEDICARE ADVANTAGE PLAN

An individual may only disenroll from an MA plan during one of the election periods described in this brochure. A beneficiary may disenroll by enrolling in another plan, giving or faxing a signed written notice to the MA organization, by submitting a request via the Internet to the MA organization, or by calling 1-800-MEDICARE. Generally, the date coverage ends will be the first day of the month after an individual requests disenrollment. Retroactive disenrollment may be granted by CMS if there never was a legally valid enrollment, or a valid request for disenrollment was properly made but not processed or acted upon.

WHAT OPTIONS ARE AVAILABLE UNDER MEDICARE ADVANTAGE?

- **Coordinated Care Plans** These plans include the following:
 - Health Maintenance Organizations (HMOs)
 - Provider Sponsored Organizations (PSOs)
 - Preferred Provider Organizations (PPOs)
- **Medical Savings Accounts (MSAs)** combine the use of a health care savings account with a high deductible catastrophic health plan.
- **Private Fee-For-Service Plans (PFFSs)** allow an individual to use any doctor or hospital as long as that provider accepts the plan's terms and conditions.
- **Special Needs MA Plans (SNPs)** designed for people who live in certain institutions, are eligible for both Medicare and Medicaid, or have one or more specific chronic or disabling conditions. A SNP is a type of coordinated care plan.

WHO'S ELIGIBLE FOR MEDICARE ADVANTAGE

An individual entitled to benefits under Part A *and* enrolled in Part B is eligible for an MA plan. An individual is eligible to enroll in a particular MA plan if the plan serves the geographic area in which the individual resides. An MA plan may not deny enrollment to an eligible individual based upon health status or certain other factors. However, individuals with end-stage renal disease (ESRD) are excluded, except that an individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in that plan. Such an individual may also enroll in another MA plan if the individual's original plan terminates its contract with CMS or reduces its service area. An individual with ESRD may, however, elect an MA special needs plan as long as that plan has opted to enroll ESRD individuals. There are also circumstances where an MA organization may accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group.

HOW TO JOIN A MEDICARE ADVANTAGE PLAN

To enroll in an MA plan, an individual must complete and sign an election form or complete another CMS approved election method offered by the MA organization. Individuals can contact their plan choice directly or call 1-800-MEDICARE to enroll. At a minimum, MA organizations must have a paper enrollment form process available for potential enrollees.

WHAT YOU PAY

Out-of-pocket costs in an MA plan depend on whether the plan charges a monthly premium, whether the plan has a yearly deductible, how much you pay for each visit or service (copayments or coinsurance), the type of health care services needed and how often and whether network providers are used. MA plans may charge cost-sharing for a service that is above or below the traditional Medicare cost-sharing for that service. However, MA plans cannot impose cost-sharing for chemotherapy administration services, renal dialysis services, and skilled nursing care services that exceed the cost-sharing for those services under traditional Medicare.

All MA plans must have a maximum allowable out-of-pocket (MOOP) limit on the amount of cost-sharing they can charge for all Part A and Part B services, with the amount to be set by CMS on a yearly basis.

WHAT TO KNOW BEFORE JOINING A MEDICARE ADVANTAGE PLAN

- MA plans can decide each year whether to offer an MA plan and may discontinue the plan after providing their enrollees with notice. MA plans can also change benefits, premiums, copays and their provider network from year to year.
- Many plans require enrollees to obtain the prior approval of their primary care physician in order to see a specialist.
- MA plans are not required to provide enrollees the same access to providers that is provided under traditional Medicare. In many plans enrollees must use the plan's providers and facilities. In other plans, enrollees must pay more to see "non-network" providers.
- Plans only cover emergency and urgent care if an enrollee is out of the service area for a brief time, but an enrollee must return to the area for follow up or routine care.
- There may be limited geographic areas where enrollees can receive care.
- It can take up to 30 days to disenroll, and an enrollee must continue to use the MA plan during this time.
- MA plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in traditional Medicare.

CONSIDERATIONS FOR SELECTING A MEDICARE ADVANTAGE PLAN

- Compare the coverage and costs available through the traditional Medicare program combined with an appropriate Medigap policy, versus the available MA plans.
- Find out whether, and to what extent, you are required to receive services from medical providers who participate in the MA plan you are considering.
- Read each plan's literature to see what kind of plan it is and what it pays for.
- Does the plan include Part D prescription drug coverage? If not, do you want to join a separate Part D plan?
- Determine what plan services are provided at additional cost. All preventive services should be identified, as well as any limitations associated with visits or services. Determine where you would go for emergency, urgently needed, and regular care.
- Check into the plan's physicians to determine if your physicians are in the plan and find out how to change physicians if a satisfactory relationship with a plan physician cannot be established. In addition, ask which hospitals, skilled nursing facilities and home care agencies the plan contracts with to ensure that there are satisfactory choices.
- Learn how to use the plan's complaint system and how appeals and grievances are handled.
- Ask a plan representative if member satisfaction surveys are conducted and if the results are available for review.
- Contact Medicare's Regional Office to determine if a plan has always complied with Medicare regulations.

The Center for Medicare Advocacy, staffed by attorneys, legal assistants, nurses, and technical experts, provides legal advice, self-help materials, and representation for older people and people with disabilities who are unfairly denied Medicare coverage and access to necessary, quality health care. The Center has offices in Connecticut, Washington, DC, and around the country.

For more information visit our website
www.medicareadvocacy.org

Individuals can obtain help and a list of MA plans in their area from their State Health Insurance Assistance Program (SHIP), the Medicare Hotline (1-800-633-4227), or the Medicare website (www.medicare.gov).

In Connecticut contact CHOICES at 1-800-994-9422.

**2016 MEDICARE DEDUCTIBLE
CO-INSURANCE & PREMIUM AMOUNTS**

PART A:

Hospital

Deductible: \$1,288

Co-insurance:

Days 1-60: \$0

Days 61-90: \$322/Day

Days 91-150: \$644/Day

Skilled Nursing Facility

Co-insurance:

Days 1-20: \$0

Days 21-100: \$161.00/Day

Home Health

No co-insurance or deductible

Part A Premium (For voluntary enrollees *only*)

\$226/ Month

(If individual has 30-39 quarters of
Social Security coverage)

\$411/ Month

(If individual has 29 or fewer quarters of
Social Security Coverage)

PART B:

Deductible: \$166/Year

Standard Premium: \$104.90 (For individuals enrolled in
Medicare in 2015 or before)

\$121.80/Month (For new enrollees after 2015)

If individual income is < \$85,000 /Year

If Ind. Income: \$85,000 - \$107,000: \$170.50 / Month

\$107,000 - \$160,000: \$243.60 / Month

\$160,000 - \$214,000: \$316.70 / Month

\$214,000 or more: \$389.80 / Month

CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.
- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:

www.MedicareAdvocacy.org