Medicare Advantage Plans

The Basics for Physicians and Patients

2014

Medicare Advantage (MA) plans – also known as Medicare Part C or Medicare replacement plans – were born out of the *Balanced Budget Act of 1997*. MA plans are similar to commercial managed care insurance plans in that patients enroll in a managed care plan where services are sought from a network of participating physicians and health systems.

MA plans were created with the expectation that managed care would be less expensive than care delivered through traditional fee-for-service Medicare. However, a patient's choice of physicians and health systems is more limited in MA plans than through traditional Medicare, as not every Medicare participating physician is part of an MA network. Some patients may begin the coverage year with an understanding that their physician is participating in the MA plan, only to discover later that the physician was terminated from the network during the plan year.

The Centers for Medicare and Medicaid Services (CMS) contracts with insurance companies to provide MA coverage to a specific group of patients through a bidding process. Insurers then provide covered services to that group of patients for a specific amount of remuneration from CMS. In other words, no matter how much it costs to care for that particular population of Medicare patients (i.e., MA insureds), the insurer will be paid only the amount agreed upon with CMS and nothing more.

Contracting and how the plan works

An MA plan is allowed to charge its beneficiaries co-pays and co-insurance amounts that, in some circumstances, are higher than the beneficiaries would have assumed under traditional Medicare. However, the tradeoff is that the patient will receive additional services through the insurance company that he/she would not have received if covered solely by traditional Medicare, such as dental and pharmacy benefits and the avoidance of the three-day hospitalization requirement prior to admission to a skilled nursing facility. An MA plan must pay for all medically necessary services that are covered under traditional Medicare.

There are four types of Medicare Advantage plans:

1. Coordinated Care Plans
   - Health Maintenance Organizations; Point-of-Service Plans
   - Provider Sponsored Organizations
   - Preferred Provider Organizations
   - Regional Preferred Provider Organizations
2. Medicare Savings Account Plans
3. Private Fee-for-Service (PFFS) Plans
4. Religious Fraternal Benefit Plans

To keep their contracts with Medicare, insurance companies are expected to continuously monitor their expenses and services offered, and ensure an integrated approach to health care – that is, focus on disease prevention, population health management and care coordination. For these reasons, MA plans may frequently survey their Medicare insureds and visit their homes for safety checks, and they will strive to better understand their patients' conditions, analyze their claims histories, and request medical records from treating physicians. Insurers use a combination of these factors to apply a risk score to each patient – these scores assist the insurance companies with estimating future losses.

MA plans are prohibited from unduly limiting choice or availability of providers or health systems to a beneficiary. Further, an MA plan is obligated to pay for emergent and urgently needed services regardless of the physicians' or health systems' participation in the plan. However, the MA plan may charge a higher cost share for services sought outside of the network.

Keep costs transparent

Beneficiaries choosing MA plans may assume that their costs will be lower due to being associated with an MA plan versus traditional Medicare and supplemental insurance. This is not always the case. There will be circumstances when deductibles and co-payments will be at a higher rate than traditional Medicare coverage. Also, beneficiaries may be paying additional premiums for MA coverage that are comparable in price to supplemental (Medigap) plus pharmaceutical (Medicare Part D) coverage.

It is critical for physicians to be transparent with their patients about network and plan participation and to point patients to resources that offer accurate explanations of Medicare coverage options. This will help patients avoid situations in which they are unable to pay deductibles or co-insurances, or are forced to seek care from another source during the course of treatment.

Resources for Physicians

Guidelines for Medicare Managed Care Plans (e.g. Medicare Advantage regulations)

Social Security Act: Free Choice by Patient Guarantee

Social Security Act: Health Insurance for the Age and Disabled (regulations)

Resources for Patients

Medicare

Medicare Supplemental Insurance Resources

Medicare Part D, Pharmacy Plans

Medicare Advantage Plans Network Comparision

Illinois Department on Aging Medicare Resources

www.isms.org

Illinois State Medical Society
(Chicago office)
20 North Michigan Ave., Ste. 700
Chicago, Illinois 60602

312-782-1654

Toll free: 800-782-4767

Illinois State Medical Society
(Springfield office)
600 South Second Street, Ste. 200
Springfield, Illinois 62704

217-528-5609

Toll free: 800-782-4767

Illinois State Medical Society

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