



Original Medicare vs. Medicare Advantage Agent Reference Material

Choices:

Beneficiaries have a choice when it comes to their coverage. They can choose to have Original Medicare, which includes Part A, Part B, and Part D coverage. Or, they can choose to enroll in a Medicare Advantage plan, which combines Part A, Part B and Part D into one package. There are numerous differences between these two options, including enrollment, coverage, network, billing, prescription coverage and extra benefits.

Enrollment:

Enrolling in Original Medicare happens during three distinct times, the Initial Enrollment Period (IEP), the General Enrollment Period (GEP), and a Special Election Period. The IEP is centered around the beneficiary's 65th birthday month, and begins three months prior and ends three months after. If the beneficiary chooses not to enroll during their IEP, they have the opportunity to enroll during the GEP which starts each January 1st and runs through March 31st, with benefits beginning on July 1st of that year.

These days, many individuals are choosing to work beyond age 65 and may delay enrolling into Medicare if they are covered by group insurance based on their or their spouse's current employment. They have the ability to enroll any time they are covered by the group plan, and up to 8 months after they lose employment or their group coverage, whichever happens first.

Like Original Medicare, enrolling into a Medicare Advantage plan can happen during specific timeframes, including the Initial Enrollment Period (IEP), Annual Enrollment Period (AEP), Open Enrollment Period (OEP), and numerous Special Election Periods (SEP). The IEP is based on the month the client receives both A&B entitlement, generally their 65th birthday month, and begins three months prior and ends three months after. Each year, all beneficiaries have the ability to enroll into/change/cancel their Medicare Advantage coverage during the AEP, which starts on October 15th and runs through December 7th, with any change going into effect January 1st.

Individuals already on a Medicare Advantage plan can utilize the OEP to make a one-time change to their coverage. From January 1st through March 31st they can change their MA coverage, disenroll and go back to Original Medicare, and enroll into a stand-alone Part D plan if they choose.

Outside of the IEP, AEP and OEP, beneficiaries may have the ability to enroll in/change/cancel their Medicare Advantage coverage utilizing a SEP. The most common SEPs are loss of group coverage, qualifying for Medicaid or Extra Help and change in residence.

[Refer to UnitedHealthcare's Election Period Grid for full details]

Coverage:

Medicare Part A covers a beneficiary if they are to receive Medicare-approved care at a facility, including inpatient hospitalizations, skilled nursing facilities, and home health care. For inpatient hospitalizations, the client must satisfy the Part A deductible before Medicare will cover the rest of their care for the first 60 days. If they are in the hospital beyond 60 days they will pay a per day copay up to 90 days. Beyond 90 days the client is utilizing their Lifetime Reserve Days, of which only 60 are available while the client is enrolled in Part A. All charges beyond the Lifetime Reserve Days are the responsibility of the beneficiary.

Part B coverage a beneficiary's outpatient Medicare-approved charges, including physician visits, outpatient tests and imaging, outpatient rehabilitation, durable medical equipment, and some medications administered at a doctor's office or outpatient facility (like chemotherapy and infusions). Each year, beneficiary's must satisfy a Part B deductible, then they receive 80% coverage for services leaving them to pay the remaining 20%. There is no maximum on the 20% a beneficiary may pay in any given year.

Medicare Advantage plans work very differently, and utilize a series of copays (set dollar amount for specific services) and coinsurances (percentage they must pay for specific services) which can be found in each plan's summary of benefits. Each Medicare Advantage plan has their own list of copays and coinsurances so benefits can vary widely between available plans.

Medicare Advantage plans have a Maximum-Out-of-Pocket (MOOP), which make them unique compared to all other parts of Medicare. All of the plan's copays and coinsurances apply towards the MOOP, giving the beneficiary an absolute limit on their annual spending for all covered services. Prescription drug costs and non-covered benefits do not apply toward the MOOP.

Network:

Beneficiaries with Original Medicare can see any doctor or facility that participate with Medicare, which is currently (2020) 93% of all doctors and over 5,300 hospitals in the country.

Medicare Advantage beneficiaries must utilize a network of providers for coverage based on the type of plan they are enrolled in:

- Health Maintenance Organization (HMO) - beneficiaries must utilize in-network providers to receive coverage for services, except in emergency or urgent care situations.
- Preferred Provider Organizations (PPO) - beneficiaries can utilize the plan's network of providers and facilities to pay the lowest copays/coinsurances for covered services. They are able to go outside of the network but will pay higher out of pocket costs, and they must still see a provider/facility that participates in the Medicare program.

Billing:

Physicians that accept Medicare are broken into two categories, either participating or non-participating.

- Participating Provider - accepts Medicare Assignment, meaning they agree that Medicare's limit for each service is payment in full. These providers bill Medicare directly for services and they are paid directly from Medicare.
- Non-Participating Provider - accepts Medicare clients, but they do not agree to accept Medicare's limit for services. They are allowed to bill up to 15% higher than Medicare's approved amount. These providers will bill Medicare directly, but Medicare will pay the beneficiary and it's the beneficiary's responsibility to pay the provider.

There are also Excluded Providers, that do not participate and are unable to bill Medicare for any services. It is the beneficiary's responsibility to cover the cost of services received from excluded providers as Medicare will not reimburse for any expenses

Medicare Advantage plans take the place of Original Medicare when it comes to billing. Providers bill the plan directly for services and the plan will pay them back directly, leaving the client to pay any applicable copays or coinsurances for covered services. If there is an issue with billing, both the provider and the client can reach out to the plan for assistance.

Extras:

Original Medicare provides few extras, but those that are provided are essential to help a beneficiary stay healthy and active. Upon enrolling in Part B of Medicare, each beneficiary qualifies to receive a full physical within 12 months of joining that will be paid 100%. Afterwards, Medicare will pay for an Annual Wellness Visit, which is a list of questions that are reviewed with the beneficiary and covers a wide range of topics including physical, emotional and mental health, medication adherence, concerns, and so on.

Original Medicare also covers a wide range of preventive services to help beneficiaries detect any illnesses or disease early, including bone mass measurements, cardiovascular disease screenings, cancer screenings, colonoscopies, diabetes screenings, mammograms, and many others.

[Visit <https://www.medicare.gov/coverage/preventive-screening-services> for more information]

Medicare Advantage plans include all of the extras from Original Medicare, plus other benefits which make the plans very attractive to some beneficiaries. These extra benefits may include (benefits vary by plan) dental, vision, hearing, fitness, transportation, chiropractic, acupuncture, annual physical, post-discharge meals, telemedicine, over-the-counter supplies, and many more. Beneficiaries can refer to their plan's summary of benefits for a full list of extra benefits.

Prescription Coverage:

Beginning January 1st of 2006, Medicare beneficiaries could enroll in Part D of Medicare to help cover the cost of their outpatient prescription drugs. Those on Original Medicare would sign up for a stand-alone Part D plan that's provided by a private insurance company.

Many Medicare Advantage plans include Part D coverage built into the coverage, so the client receives their health and Rx benefits from one company. These Medicare Advantage Prescription Drug plans are referred to as MAPDs. Clients with a PFFS Medicare Advantage plan have the option to purchase a stand-alone Part D plan.