

Legal Basics: Medicare Part C & Medicare Advantage

CHAPTER SUMMARY • March 2018

Georgia Burke and Natalie Kean, Justice in Aging

Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Key Lessons

- 1. Medicare Part C is the Medicare Advantage (MA) Program.** The MA program provides coverage of Medicare benefits through private managed care plans. Most Medicare Advantage plans are either health maintenance organizations (HMOs) or preferred provider organizations (PPOs). Special Needs Plans (SNPs) are MA plans that are limited to specific types of Medicare beneficiaries and provide services tailored to their needs.
- 2. Medicare Advantage is different from Original Medicare.** MA plans may require beneficiaries to see certain providers or receive prior authorization for certain services. All MA plans have out-of-pocket limits on costs and some plans charge fixed dollar copayments instead of coinsurance. MA plans can also provide care coordination and supplemental benefits such as dental or vision care that Original Medicare does not cover.
- 3. Medicare beneficiaries can choose to enroll in an MA plan when they first become eligible for Medicare or during the annual open enrollment period.** Each fall, there is an annual open enrollment period during which Medicare beneficiaries can enroll in or switch MA plans, or change from MA to Original Medicare. Additional opportunities may be available depending on individual circumstances.
- 4. Medicare Advantage uses a different appeals process than Original Medicare.** If an MA plan denies coverage of a service, the beneficiary must first ask the plan to review its decision. After that, the next level of review is the Part C Independent Review Entity (IRE).

Glossary

Original Medicare

Original Medicare refers to the Part A hospital benefit and Part B medical benefit, which have been part of Medicare since the program was first created in 1965. It is also sometimes called “traditional Medicare” or “Fee-for-Service Medicare.”

MA-PD

A Medicare Advantage plan that includes a prescription drug benefit.

Special Needs Plans (SNPs)

Medicare Advantage plans designed to serve individuals with particular needs. There are three types: D-SNPs for individuals dually eligible for Medicare and Medicaid, C-SNPs for individuals with a particular chronic condition, and I-SNPs for individuals residing in long-term care facilities.

Qualified Medicare Beneficiaries (QMBs)

Qualified Medicare Beneficiaries (QMBs) are low-income Medicare beneficiaries who qualify for a Medicaid program that pays for their Medicare Part A and B premiums, deductibles and co-payments. QMBs automatically receive Part D's low-income subsidy, called "Extra Help." QMB benefits are available both to individuals in Medicare Advantage plans and to those in Original Medicare.

Summary of Benefits and Coverage

A document that explains what services a particular Medicare Advantage plan covers and what the Medicare beneficiary is expected to pay for them. It is a useful tool to compare plan choices.

Utilization Management

Techniques that Medicare Advantage plans use to limit or regulate coverage of a particular service.

Prior authorization (PA)

Prior authorization, or preauthorization, is the most common utilization management technique whereby a plan must approve a service before it is provided. Examples include requiring a beneficiary to see a primary care provider before a specialist or try a less expensive treatment.

Medicare Parts A, B, C, D

Medicare has four parts: Part A covers hospital services, Part B covers outpatient services, Part C is Medicare Advantage, and Part D covers prescription drugs.

PDP

A prescription drug plan. Medicare beneficiaries can get prescription drug coverage through Part D stand-alone PDPs or through an MA-PD.

Dual Eligible

An individual who is eligible for both Medicaid and Medicare.

Medigap plans

Also called Medicare supplement plans, Medigap plans are private plans that provide supplemental insurance coverage designed specifically to work with Original Medicare. Depending on the plan, they cover all or part of Medicare Part A and Part B deductibles, copays, and coinsurance. Medigap plans are different from Medicare Advantage plans and cannot be used together.

Medicare Advantage Enrollment and Coverage

What are Medicare Advantage plans?

Medicare Advantage (MA) plans are managed care plans offered to Medicare beneficiaries as an alternative to Original Medicare. Approximately one-third of the Medicare population is enrolled in Medicare Advantage.

Who can join a Medicare Advantage plan?

Medicare beneficiaries must be enrolled in both Medicare Part A and Part B to join an MA plan. With some exceptions, people with End-Stage Renal Disease (ESRD) may not enroll, but plan members who develop ESRD after enrollment may continue with their plan.

What do Medicare Advantage plans cover?

MA plans cover all Medicare Part A services (the hospital benefit) and all Medicare Part B services (the medical benefit). Most MA plans are MA-PD plans, meaning that they also provide Part D prescription drug coverage. Some MA plans also offer "supplemental benefits" not covered by Original Medicare, such as dental or vision benefits.

Differences Between Medicare Advantage Plans and Original Medicare

The primary differences between Medicare Advantage and Original Medicare are:

Provider choice. Most MA plans are health maintenance organizations (HMOs) and require members to use only in-network providers. Some are Preferred Provider Organizations (PPOs), meaning that members can use out-of-network providers but will pay more if they do so. In Original Medicare, an individual can choose any Medicare provider.

Prior authorization. MA plans frequently require that a member get prior authorization before visiting a specialist or for other procedures. In Original Medicare there usually is no prior authorization requirement.

Payment structure. MA plans usually have set co-payments for most services, e.g., \$30 for a doctor visit. With much of Original Medicare, the individual pays a percentage of the Medicare-approved amount. Also, MA plans are required to have an out-of-pocket limit on cost-sharing for all Part A and Part B services. MA plans can change these cost-sharing amounts at the beginning of the coverage year in January.

Care coordination. MA plans offer various types of care coordination services to their members that are not part of Original Medicare.

Star Ratings. Medicare uses a Star Rating System to measure MA plan performance. Medicare rates plans from one to five stars, with five being the highest, on how well they perform overall and in several categories, including quality of care and customer service. These ratings are available to beneficiaries as they compare plan options.

The Three Categories of Specialized MA Plans

There are three categories of specialized MA Plans, known as Special Needs Plans (SNPs). SNPs limit their enrollment to specific groups of individuals and provide services geared to those groups.

Dual Eligible Special Needs Plans (D-SNPs) are limited to individuals dually eligible for Medicare and Medicaid. Some D-SNPs limit their enrollment to individuals with full Medicaid benefits; others also enroll individuals who only qualify for Medicare Savings Programs.

Chronic Condition Special Needs Plans (C-SNPs) are limited to individuals with particular chronic conditions, e.g., a C-SNP for people with chronic heart failure.

Institutional Special Needs Plans (I-SNPs) are limited to individuals residing in long-term care facilities.

In addition to the three SNPs, in nine states participating in the financial alignment demonstration, there are Medicare-Medicaid plans (MMPs) that offer Medicare Advantage services and Medicaid managed care together in one plan.

Other types of MA plans that are less frequently encountered by advocates for low-income beneficiaries are Private Fee-For-Service (PFFS) plans and Medicare Medical Savings Account plans.

PRACTICE TIPS

Picking a plan

John is considering joining a Medicare Advantage plan. Where should he start?

The Medicare Plan Finder will help John find available plans in his area.¹ He will want to:

- Look at which of his current providers are in the plan network. Which hospitals are in the network? Which of his prescription drugs are on the plan's drug list?
- Look beyond premiums and consider the plan's co-payment structure to better understand what his total costs might be.
- Consider any supplemental benefits the plan might offer. If John receives Medicaid, some of the supplemental benefits might already be covered under his Medicaid benefit.
- Look at the plan's star ratings to see how the plan compares to others in the area.
- Talk to a SHIP counselor to get free unbiased assistance.²

Changing plans

Isabella joined a Medicare Advantage plan during the annual Open Enrollment Period but, after trying it, she finds that the plan doesn't meet her needs. Can she change back to Original Medicare?

Starting in 2019, Isabella will be able to make one change during the first three months of each year (Jan. 1-Mar. 31). She can change to a different MA plan or switch to Original Medicare with a PDP.

If Isabella receives the Medicare Low-Income Subsidy (LIS), also called "Extra Help," she can change her coverage at any time. The change will be effective the first day of the following month.

If there is a plan with a five star quality rating in her area, she can switch enrollment to that five star plan at any time.

If none of the above situations apply, Isabella will have to wait until the next Open Enrollment Period (Oct. 15-Dec. 7), unless she qualifies for a Special Enrollment Period (for example, if she moves into or out of a nursing home).

NOTE: *An individual who is eligible to change plans can do so by either calling 1-800-Medicare or calling a new MA plan or a PDP to enroll. The new enrollment will automatically cause disenrollment from the old plan.*

MA plans and improper billing of QMBs

Peter is a Qualified Medicare Beneficiary (QMB) who belongs to an MA plan. His in-network plan doctor's office collects a \$30 co-pay at every visit. Does Peter owe this money?

No. QMB billing protections apply in MA plans just as they do in Original Medicare. Both Peter's doctor and Peter's MA plan are responsible for ensuring that Peter is not billed and that amounts he paid in error are refunded.³

Service denials

Sophia's MA plan denied her request for knee surgery. What can she do?

Sophie received a written denial, called an Organizational Determination. She must begin her appeal by asking the plan to reconsider the Organizational Determination. If the plan decides against Sophie's reconsideration request, in whole or in part, her appeal is automatically sent to the Part C Independent Review Entity (IRE) for review. After that, Sophie can seek further review by an Administrative Law Judge, then the Medicare Appeals Council and then Federal District Court.⁴

Legal services attorneys can be especially helpful with the IRE review and any further appeals. Plan determinations are frequently reversed at these higher levels.

NOTE: *An expedited review process is available when the plan member's treating physician attests that delay would endanger the life or health of the individual.*⁵

MA plans and Medigap

Andrew is in Original Medicare with a Medigap (also sometimes called "Medicare supplement") policy. He is confused about the relationship of Medigap and MA plans.

Generally, people in MA plans do not need Medigap policies and get no benefit from them. Medigap policies help individuals with their costs in Original Medicare and do not cover any MA costs. Agents and brokers are forbidden to sell a Medigap policy to someone enrolled in Medicare Advantage. If Andrew chooses to enroll in an MA plan and drops his current Medigap plan, however, he may have difficulties getting a Medigap plan later if he goes back to Original Medicare. Rules vary by state so it is a good idea for him to talk to a SHIP counselor to understand his options.⁶

Conclusion

Medicare Advantage is an option Medicare beneficiaries can choose to get their Medicare benefits through private managed care plans. Although MA plans are required to cover all Medicare Part A and Part B benefits, how plans cover those benefits is different from how they are covered through Original Medicare. Therefore, it is important for beneficiaries considering enrolling in MA to carefully review plans' provider networks, prescription drug coverage and cost sharing to ensure their health care needs will be met.

Additional Resources

- Georgia Burke, Justice in Aging, gburke@justiceinaging.org
- Natalie Kean, Justice in Aging, nkean@justiceinaging.org
- Statute: Section 1851-1859 of the Social Security Act, 42 U.S.C §§ 1395w-21 to 1395w-28
- Regulations: 42 C.F.R. Part 422
- Guidance: [Medicare Managed Care Manual](#)
- Official Medicare Website: [Medicare.gov](https://www.medicare.gov)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

Endnotes

- 1 Go to [medicare.gov/find-a-plan/questions/home.aspx](https://www.medicare.gov/find-a-plan/questions/home.aspx).
- 2 State SHIP contacts can be found at shiptacenter.org.
- 3 For more information on billing protections for QMBs, visit the CMS QMB webpage at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html) and the Justice in Aging Improper Billing Toolkit page at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html)
- 4 For additional details on the appeals process, go to the CMS Medicare Managed Care Appeals and Grievances webpage, [cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html).
- 5 Note also that the special expedited review procedure for discharge from a hospital, skilled nursing facility, or home health services that is available to individuals with Original Medicare also is available for individuals in MA plans. See BFCC-QIO Review at [cms.gov/Medicare/Appeals-and-Grievances/MMCAG/BFCC-QIO-Review.html](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/BFCC-QIO-Review.html).
- 6 Andrew has a one-year trial period the first time he joins an MA plan. After that, in some states, Medigap insurers are allowed to consider pre-existing conditions. For a summary of federal policy, go to [medicare.gov/find-a-plan/staticpages/learn/rights-and-protections.aspx](https://www.medicare.gov/find-a-plan/staticpages/learn/rights-and-protections.aspx). Additional state protections may apply.

This Chapter Summary was supported by a contract with the National Center on Law and Elder Rights, contract number HHSP233201650076A, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.