How to Perform a Medicare Advantage Plan Comparison

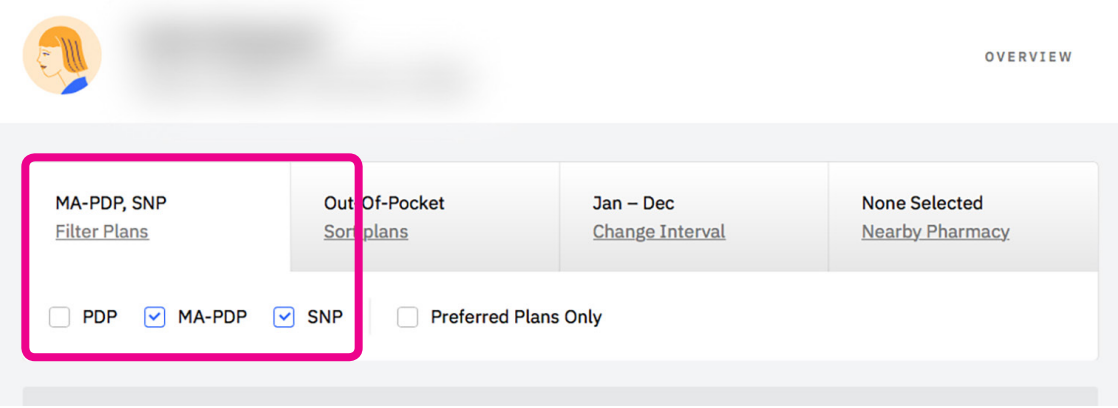
Amplicare

Follow this guide to master the ins and outs of performing a Medicare Advantage plan comparison

Medicare Advantage Plans (MA-PDP), also referred to as Medicare Part C, are plans that roll a patient's hospital, medical, and drug coverage all into one. Patients on these plans will still have Medicare Part A and Medicare Part B, but all hospital, medical, and drug coverage comes from a private insurance company. When comparing Medicare Advantage Plans, there are additional factors to consider that do not apply to performing a traditional Medicare Part D plan comparison.
This guide explains what some of these extra components mean and how they will impact your patients.

Step One

To compare Medicare Advantage Plans for a patient, first select MA-PDP (and SNP, if applicable) from the **Filter Plans** option at the top of the patient's *Medicare* page.

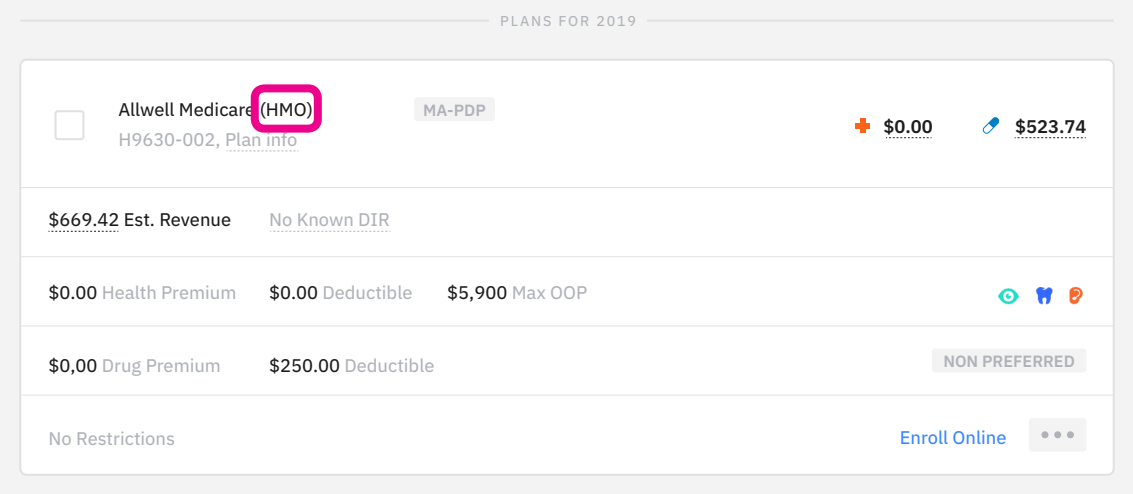


This will list only Medicare Advantage Plans (and Special Needs Plans, if applicable) as options to compare.

Step Two

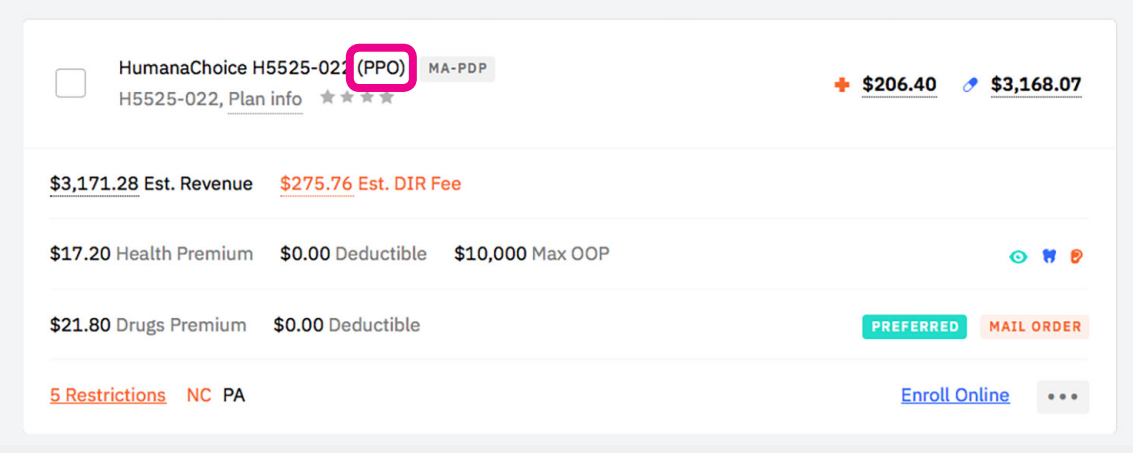
Now that you have narrowed down plans for comparison it is time to determine what **Type** of MA-PDP would be best for the patient. There are five types of MA-PDPs: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-For-Service Plans (PFFS), Point of Service Plans (POS), and Special Needs Plans (SNP). It's important to understand the differences between these types of plans because **they determine how provider networks (or lack thereof) are structured**.

Health Maintenance Organizations (HMO)



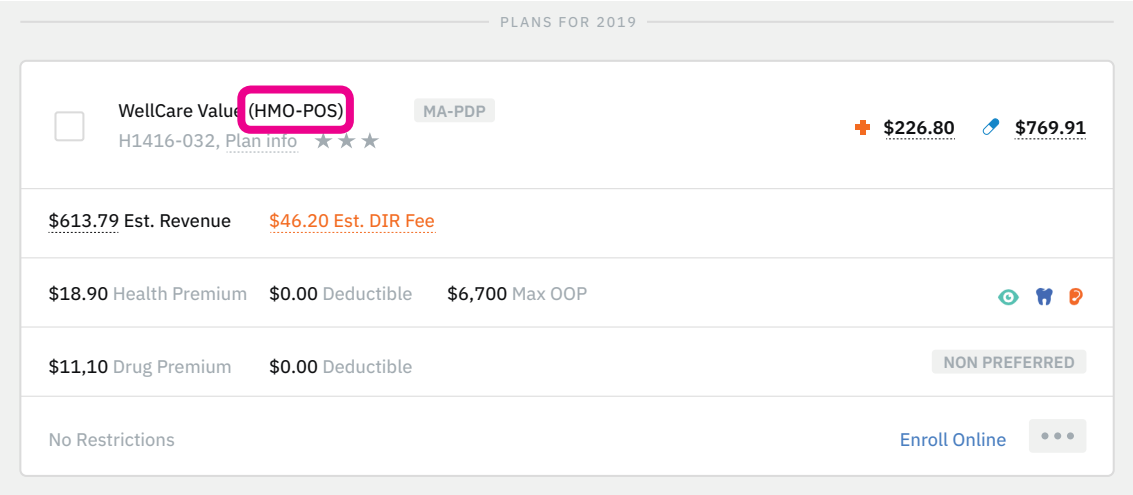
HMOs require patients to choose an in-network primary care provider who can then refer them to various in-network specialists and services. However, be aware that patients on these types of plans can only receive services from in-network providers, except in emergency situations.

Preferred Provider Organization (PPO)



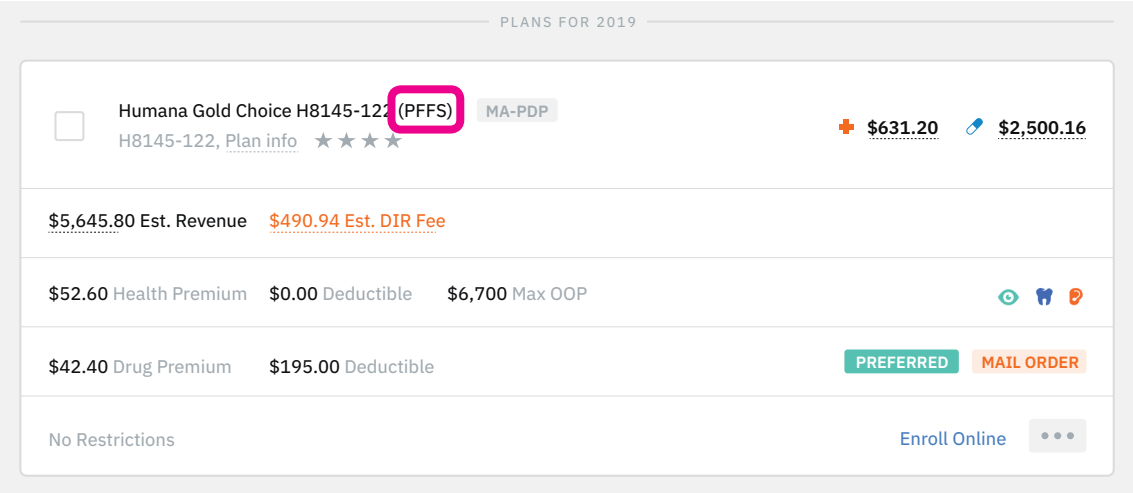
A **PPO** is similar to an HMO, but these plans tend to provide a larger network of doctors and providers for patients to choose from. Premiums and deductibles here tend to be higher than those of HMOs.

Point of Service (POS)



A **POS** is a hybrid between an **HMO** and a **PPO**, where patients will choose an in-network primary care physician, but can seek out additional services that are out of network at the cost of higher copayments. POS plans are not very common, and you will typically see a joint HMO POS more often than a standalone POS plan. On this type of plan, the patient can choose if he/she wants to use the HMO or POS services each time he/she sees a provider.

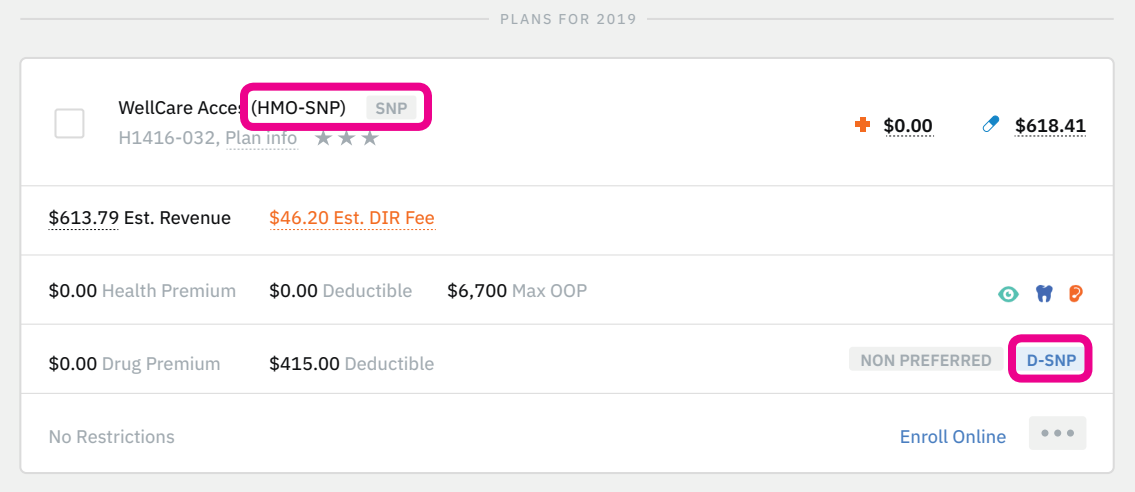
Private Fee For Service (PFFS)



PFFS plans differ from other Medicare Advantage plans in that the insurance provider, not Medicare, determines how much it will pay for a service and how much falls on the patient. PFFS are contracted with all Medicare-participating providers who accept their terms. There may or may not be a provider network, but patients are often allowed to go

out of network regardless (always double check to be sure). Something to be aware of: providers can accept the terms of the PFFS on a case by case basis, meaning that a patient who saw a provider once may not be accepted again depending on the service needed. Patients should confirm that their providers accept their PFFS on every visit.

Special Needs Plan (SNP)



SNPs are specific plans that provide specialized care for certain groups of patients. There are three types of SNPs (and each SNP will be tagged accordingly with a little blue tag as shown above).

D-SNP: This is the most common SNP. The patient must be dual eligible (receiving both Medicare and Medicaid) to enroll.

C-SNP: These are Special Needs Plans for patients with certain chronic health conditions. They are only available to patients in some counties. The most common C-SNPs are for patients with diabetes or heart disease.

I-SNP: These SNPs are available for institutionalized patients in LTCs, such as skilled nursing facilities, LTC nursing facilities, intermediate care facilities, or assisted living facilities. They are also available for patients who live at home but require an institutional level of care, also called Institutional Equivalent.

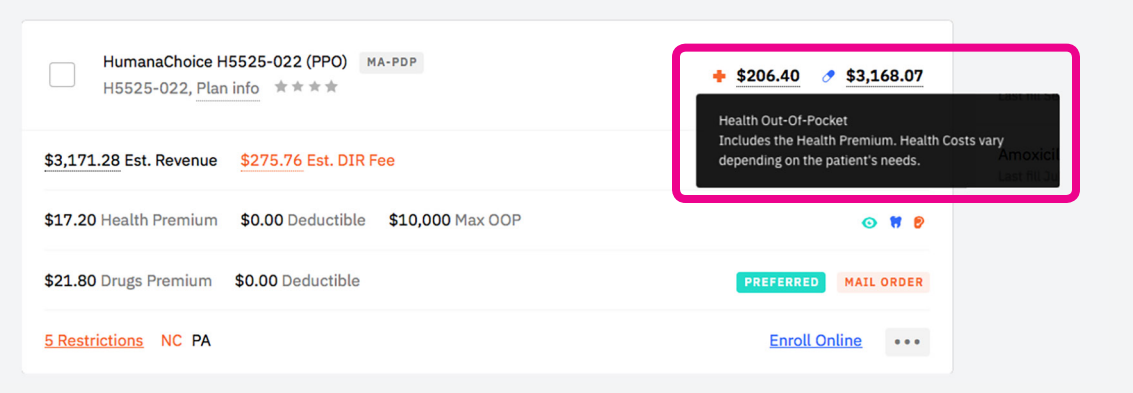
Understanding the ins and outs of each type of MA-PDP is essential in helping your patient choose the best plan for his/her unique needs.

Step Three

It is important that you and your patient understand the different components of Medicare Advantage Plans. While performing a Medicare Part D plan comparison is somewhat straightforward, showing each drug the patient will take for the year and predicting what phases of coverage the patient will go through, there are many more factors to weigh in

comparing MA-PDPs. Not only do patients have to consider their drug out-of-pocket costs, they also have to think about the various health and medical services they will need throughout the year.

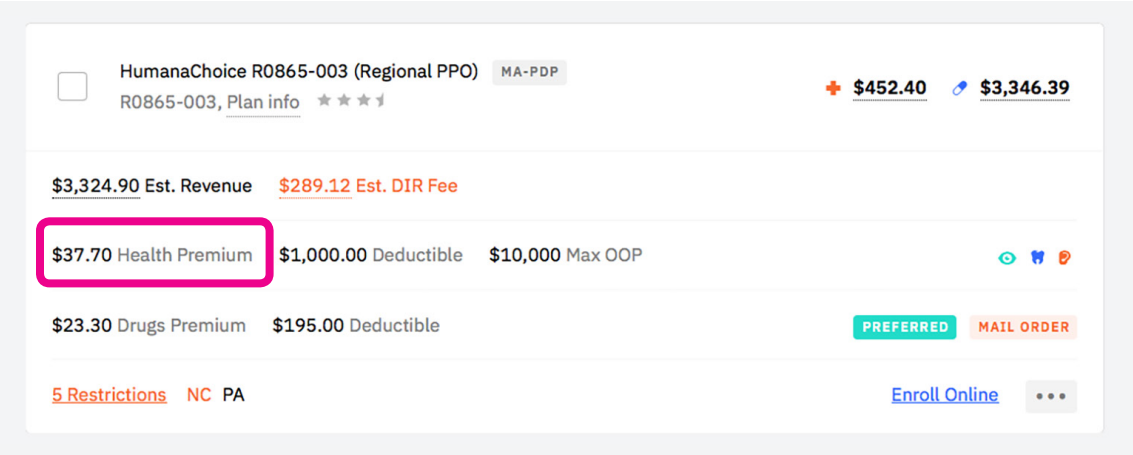
Health Out-Of-Pocket



This is the estimated total **Health Out-Of-Pocket** cost for all of the patient's health and medical services throughout the year. This includes the Health Premium (the monthly fixed amount a patient pays to his/her provider for insurance coverage), and the various out-of-pocket costs the patient will incur for doctor visits, medical services, and other extra benefits throughout the year. In Amplicare this OOP cost **only** takes into account the Health Monthly Premium, because this is the only predictable and guaranteed out-of-pocket cost the patient will have to pay for his/her health services.

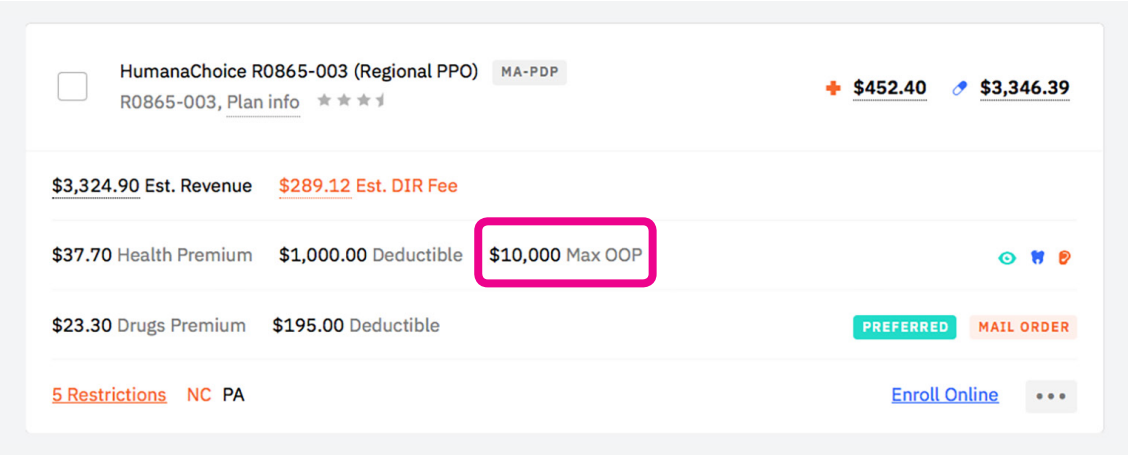
Health Out-Of-Pocket cost does **NOT** include Drug Out-Of-Pocket costs. You will notice the Drug Out-Of-Pocket cost next to the blue pill icon just like you would see while doing a PDP plan comparison.

Health Premium



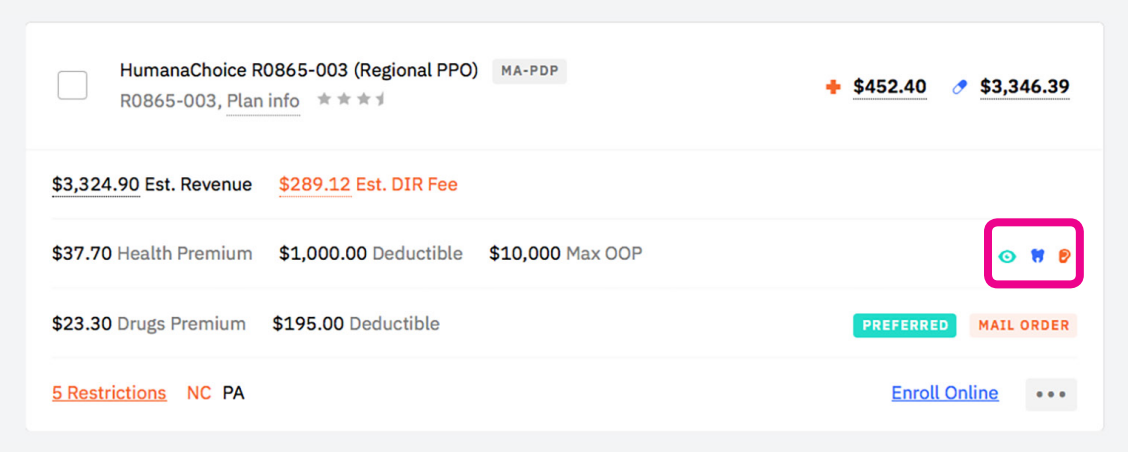
The **Health Premium** is the fixed monthly amount a patient will pay his/her insurance provider for coverage. Some plans do not have monthly health premiums. In addition, this Health Premium will be paid **on top** of the patient's Medicare Part B premium.

Maximum Out-Of-Pocket



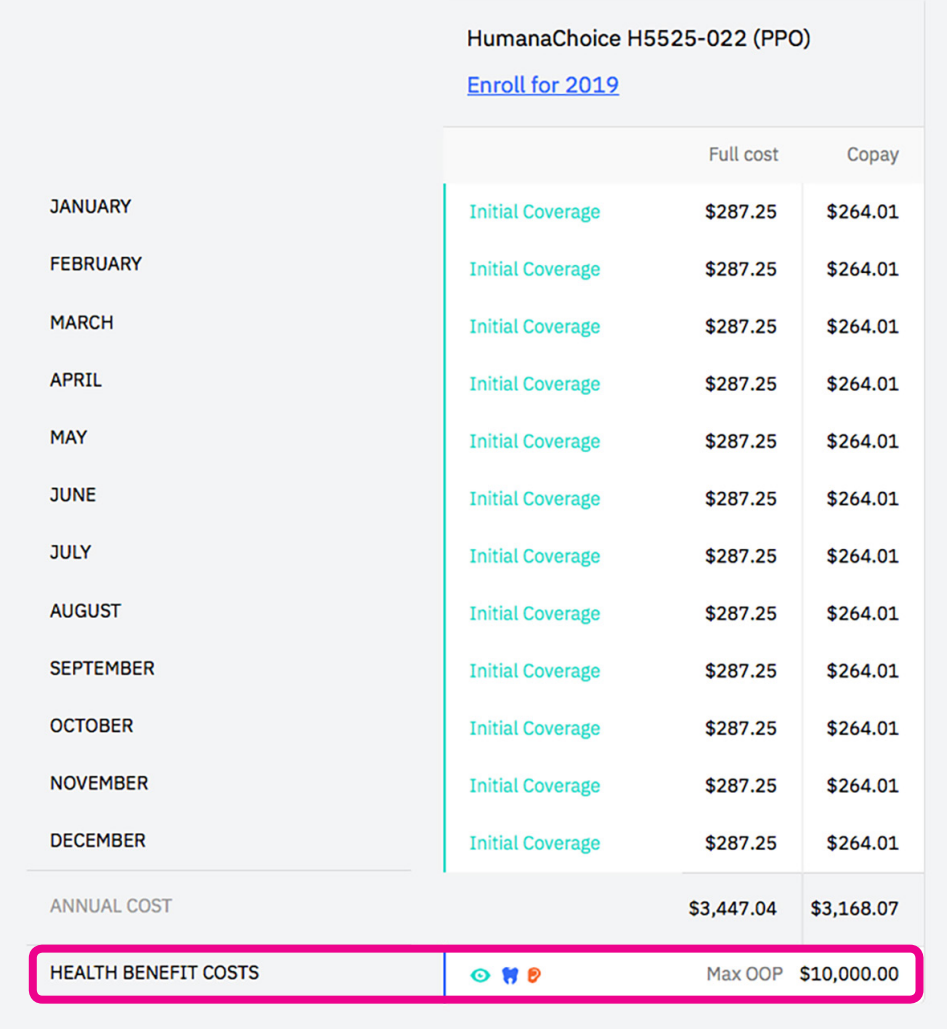
The **Maximum Out-Of-Pocket** cost is the plan's limit on how much money a patient will have to pay out-of-pocket for in-network health services throughout the year. This does **not** include out-of-network doctor/provider visits. This Maximum Out-Of-Pocket cost also does **not** include the patient's Drug Premium, Drug Deductible, and Drug Out-Of-Pocket costs.

Medicare Advantage Plans may include additional benefits, such as **vision**, **hearing**, and/or **dental** coverage. Be aware that these benefits may be limited, and further investigation into each plans' limits is advised when choosing the best plan for your patient.

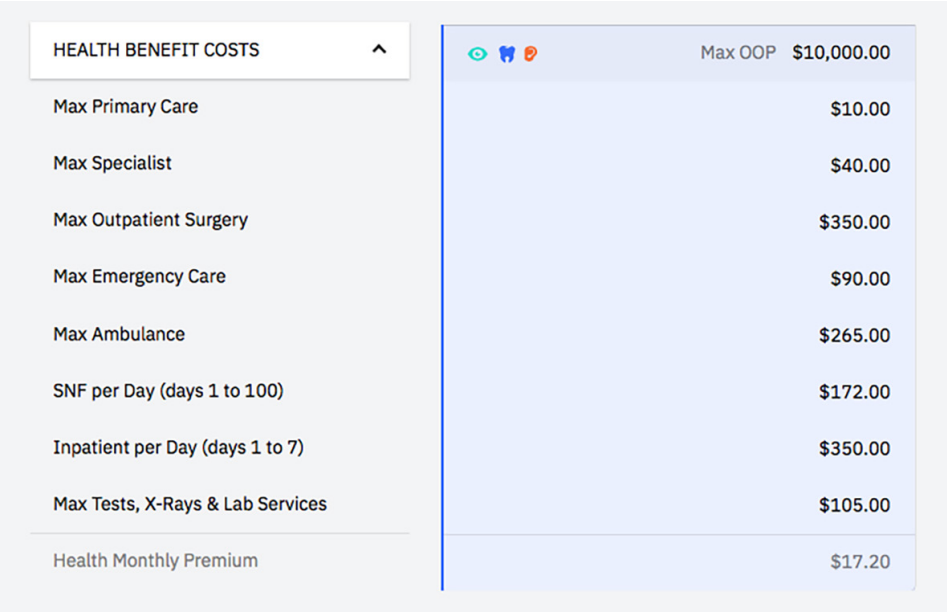


Step Four

Now it's time to dive a little deeper into how each plan structures its Maximum Out-Of-Pocket costs by type of service. Once you choose a plan or two to compare and enter the Monthly Cost page, you can find the **Health Benefit Cost Breakdown** at the bottom of each plan's column under **Annual Cost**.



To expand, simply click anywhere in this row and you will see a breakdown of the Maximum Out-Of-Pocket costs for each type of health and medical service. These costs make up the total Maximum Out-Of Pocket. This breakdown will give you and your patient a clearer picture of costs for each type of service a plan provides.



Step Five

Once you and your patient have narrowed your search down to a few different MA-PDP options, it is important to do some research on each plan's provider network.

For most MA-PDP plans, it is vital for a patient to know what doctors are in-network before choosing a plan. One downside to some MA-PDP plans is that they offer a very limited network of doctors, and a patient may lose their trusted family physician if they are not careful when selecting a plan. To determine if a doctor is in-network for a given plan, patients can use the online search tools on the plan's website. Patients may also call the plan's customer service team and speak with a representative to gather this information. Once your patient has browsed through a list of in-network providers, it is recommended that he/she call the provider directly to confirm network status. There have been cases of inaccurate reporting of provider networks in years past, and it never hurts to be too careful.

Medicare Advantage Plan Disenrollment Period

As of 2019, there is a new Medicare Advantage Open Enrollment period running from January 1st to March 31st. In the past, patients enrolled in MA-PDPs had the option to switch back to Original Medicare if they were not satisfied with their current plans. This means that patients could drop their advantage plans and enroll in Medicare Part A and B and sign up for a Part D plan as well. Patients can now, in addition, switch to a new MA-PDP plan if they feel that a different advantage plan would be more beneficial for them.