Medicare Part C – Medicare Advantage

The original Medicare program, created in 1965, consists of Part A (hospital insurance) and Part B (medical insurance) and operates as a "fee-for-service" system. Under this program, a Medicare beneficiary can go to any physician or health facility nationwide which accepts Medicare payments.

An Alternative To Traditional Medicare

In 1997, the federal government created, as Medicare Part C, the Medicare+Choice program. This new program was designed to give Medicare beneficiaries access to a wide array of more cost-effective, private health plan choices, as an alternative to the traditional Parts A and B. In 2003, Medicare+Choice was renamed as "Medicare Advantage", as part of the Medicare Prescription Drug, Improvement, and Modernization Act.

Options Under Medicare Advantage

In general, each Medicare beneficiary is entitled to choose to receive benefits through either the original Medicare fee-for-service program under Parts A and B or through a Medicare Advantage plan. The Medicare Advantage options include:

- Health Maintenance Organizations (HMO) plans
- Preferred Provider Organization (PPO) plans
- Private Fee-for-Service (PFFS) plans
- Special Needs Plans (SNPs)
- HMO Point-of-Service (HMOPOS) plans
- Medical Savings Account (MSA) plans

Benefits Under Medicare Advantage

Medicare Advantage plans are required to provide the same benefits that are covered under the traditional fee-for-service plan, except for hospice care; original Medicare will cover the cost for hospice care. Most Medicare Advantage plans offer extra coverage, for example vision, hearing, dental, and other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to the Part B premium, an enrollee in a Medicare Advantage plan may have to pay an additional monthly premium.

Medicare Part C – Medicare Advantage

Medicare Advantage plans have a yearly limit on an enrollee's out-of-pocket costs for medical services. Once this limit is reached, an enrollee will pay nothing for covered services. Each plan has a different limit and the limit can change from year to year.

Making a Choice

Once a plan has been elected, that choice will remain in effect until the beneficiary changes it or the plan chosen no longer services the area in which the beneficiary resides.[1] If a beneficiary fails to make an election, he or she will remain in the traditional fee-for-service program.

- **Initial Medicare eligibility:** Beneficiaries who enroll in a Medicare Advantage plan when they first become eligible for Medicare benefits can change to the fee-for-service plan at any time during their first 12 months of enrollment. During this period they will have an extended period of guaranteed access to Medigap plans.
- **Annual enrollment:** An annual enrollment period takes place each fall, from October 15 through December 7. Elections made during this annual enrollment period take effect January 1st of the following year. As a part of the annual enrollment, Medicare beneficiaries will be provided with information about each health plan available to them. The purpose of this information is to allow Medicare beneficiaries to make informed health care choices, based on comparative data regarding quality and performance.
- **Special enrollment periods:** Special enrollment periods are available after the end of the continuous open enrollment if: (1) a plan is discontinued; (2) the Medicare beneficiary moves; (3) the plan violates its contract with Medicare; or (4) the Medicare beneficiary encounters exceptional conditions (to be specified in regulations).

[1] Not all Medicare Advantage options are available in all geographical areas.