Chapter 5.
Medicare Advantage

Truths and Myths

Truth: The premiums, deductibles and copays change every year, so the best overall plan for you can also change.

Truth: Networks must be carefully examined in advance to minimize overall costs.

Myth: Medicare Advantage is always worse than Medigap. Factually not true. Medicare Advantage plans may include important extra benefits (example: chiropractic services).

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Medicare Advantage is a plan offered by insurance companies. The insurance company administers all aspects of benefits and your financial obligations. Medicare Advantage essentially replaces your original Medicare card, the Medicare Advantage card is to be presented to healthcare providers and pharmacies. At the end of 2018, Medicare Advantage plans represent 36% of all Medicare beneficiaries, and the popularity of these plans is growing rapidly, a trend that is likely to continue for the immediate future.

In many locations in the U.S., there are at least 20 Medicare Advantage plans, and in some areas, there are as many as 60 separate Medicare Advantage plans available. You need to be enrolled in both Part A and Part B in order to eligible, you cannot have Part A alone.

A Medicare Advantage plan must cover at least what original Medicare covers, on average.[1] There are many different types of Medicare Advantage (also known as MA) plans. Medicare Advantage plans that include prescription drug benefits are frequently referred to as MAPD (Medicare Advantage Prescription Drug) plans. You have received, or you will receive many, many advertisements via mail regarding Medicare Advantage plans. You can also see the available plans in your area on the official Medicare website, as well as in the most recent physical copy of Medicare and You.

Enrollment

Medicare Advantage Initial Enrollment

The Medicare Advantage Initial Coverage Election Period (ICEP) is specific to Medicare Advantage plans. The ICEP is not necessarily the same as the Medicare Part B or Medicare Part D Initial Enrollment Period (IEP). Under the ICEP, the first date that you can enroll for a Medicare Advantage is the same as if you are enrolling in Medicare Part B. However, the last date of the ICEP can differ, and that is the source of confusion. It is a bit convoluted and can probably be made clear through an example.

Let’s go back to John Smith, born on March 22, 1951.

Case 1. Turning 65 years old and not working. In this example, December 1, 2015 is the first date he can enroll in MA/MAPD and the last date that he can enroll is June 30, 2016, that is the end of John’s ICEP. This is the same day he could enroll in Medicare Part B or Part D alone. It is important that these are the same ONLY when turning 65 years old.

Case 2. Retiring after 65 years old. If John Smith is a full-time employee, with health and prescription drug benefits that qualified as creditable coverage, until July 30, 2016, and his Part B effective date is August 1, 2016. His Medicare Advantage Initial Coverage Election Period (ICEP) would end on November 30, 2016. The problem here with waiting until the end of the ICEP is that the Part D Late enrollment penalty begins after 63 days, not after 90 days. Bottom line: it is not a good idea to wait until the last day of any enrollment window.

In Case 1, if you are turning 65 years old (and ONLY in that instance), you preserve the flexibility to change from Medicare Advantage to Medigap during your 12-Month Trial Period. That will preserve the maximum number of options for you, because you can change your mind, and select a Medigap policy, without medical underwriting questions. This subtle option does not exist in Case 2. Under Case 2, a person would need to pass medical underwriting in order to apply for Medigap, if a Medigap policy is not initially selected.[2]

Under Case 2, John Smith can elect any Medicare Advantage plan, or can enroll in Medigap without medical underwriting, along with a Part D plan. However, John Smith does NOT have the 12-month trial right, to switch from Medicare Advantage to Medigap, unless within the first 6 months of enrolling in Part B (irrespective of age).

Candidly, this is quite a mess, due to the fact that the same terminology (Initial Coverage Election Period, ICEP) is used for both Case 1 and Case 2. The Medicare Advantage 12-Month Trial Right is powerful, but it can only be used by those first turning 65 years old. All is not lost because the person may be able to enroll in Medigap due to a different permission (Medigap open enrollment). That said, you would need to be an expert in order to manage the very subtle timeframes described in this section of the book.

The way to resolve all of this? Enroll in Part B to be effective on your first eligibility date, and carefully decide between Medicare Advantage and Medigap, to be effective on your Part B effective date. From that point, you will have preserved the maximum flexibility under the rules, under either Case 1 or Case 2.

Medicare Advantage Annual Election Period

When you are older than 65, enrolling in a Medicare Advantage or an MAPD plan is straightforward. You can enroll in any Medicare Advantage plan during the Annual Election Period (AEP). That occurs every year during the fourth quarter. In 2019, the AEP runs from October 15 through December 7, a period of seven weeks.

During the Annual Election Period, will be able to freely change your mind, as many times as you would like. The last plan that you elect will be the plan that is in effect on the following January 1. Since there is no restriction to the number of times that you can change your mind, it may be reasonable to choose the first plan so that you don’t forget, and then you can go and shop around for different plans to the extent that you find the one that is superior to your initial selection. You may have misgivings about this, but the practical reality is that the Medicare system does the cancelling for you.

Medicare Advantage 12-Month Trial Right

If you enroll in a Medicare Advantage plan before the date that you are first eligible for Medicare Part A and Part B at the age of 65, then you can cancel at any time during your first twelve months under that plan, and return to original Medicare. You can then enroll in a Medigap plan (along with a standalone prescription plan, Medicare Part D), or simply stay with original Medicare.

Open Enrollment Period

This Medicare Advantage Disenrollment Period no longer exists, beginning in 2019. Instead, a NEW enrollment period will run between January 1 and March 31, 2019, called the Open Enrollment Period. Here is what you can and cannot do.

• If you are a Medicare Advantage policyholder, you can change among plans, once. This can be valuable for those that want to add prescription coverage under Medicare Advantage (MAPD).

• If you are a Medicare Advantage policyholder, you can cancel your Medicare Advantage plan return to Medicare Part A and Part B. This will allow you to separately choose a Medicare Part D plan. Note that this does NOT guarantee acceptance into Medigap. Medigap underwriting rules are still in full effect.[3] This means that people that want to use this period to switch from Medicare Advantage to Medigap can do so, but it is very important to first secure acceptance into Medigap. Not doing so could result in a person having Part A, Part B, and Part D, but no other coverage. That would leave you responsible for the Part A inpatient hospital deductible, the Part A copays, and the 20% coinsurance not paid by Medicare Part B.

• You cannot change among Medicare Part D plans.
• You cannot switch from Medigap to Medicare Advantage.
• You cannot be a first-time enrollee in Medicare Advantage. This period is only “open” to those that are already Medicare Advantage policyholders.
• You can enroll in original Medicare (Part A and Part B) if you have not correctly enrolled in Medicare when you were first eligible. Your effective date will not be until July 1 of that year.

Special Election Periods (SEP)

The Medicare system allows people that have special situations to be able to elect a Medicare Advantage plan outside the Annual Election Period.

Here is a list of 12 of them. There are more than this, and additional ones can be added by the CMS with little advance notice.

Moving: If you have moved, and your previous plan isn’t offered in your new location, OR if you have moved and the new plan wasn’t available in your old location, then you qualify. If you move from outside the U.S., where you were living permanently, then you qualify.

Medicaid Status Change: If your Medicaid status changes, then you qualify.

Limited Income Subsidy (“Extra Help”): If you are eligible for the Limited Income Subsidy (“Extra Help”), then you can change without restriction at any time during the calendar year, once per quarter for the first three quarters in a year. You can additionally change plans during the Annual Election Period.

Skilled Nursing Facility Care: If you are moving in OR out of a skilled nursing care facility, then you qualify.

PACE (Program of All-Inclusive Care for the Elderly): If you leave a PACE program, then you qualify. Note: PACE is only available in selected states.

Loss of Creditable Coverage: If your prescription drug benefits are ruled to no longer be creditable coverage, then you qualify. Note: “creditable coverage” is defined in the Glossary.

Employer-sponsored Plan Change: If you are losing your coverage from an employer-sponsored benefit plan, then you qualify.

Pharmacy assistance program: If you are either entering a Qualified State Pharmaceutical Assistance Program (SPAP), or if you have lost your eligibility, then you qualify.

Other prescription drug assistance: If you no longer qualify for other prescription drug assistance that you have been receiving, then you qualify for an SEP.

Medicare Advantage Plan Cancellation: If your Medicare Advantage plan is no longer in existence, then you qualify (you must elect this SEP only between December 8 and the end of February of the following year).

Medicare Open Enrollment: Between January 1 and March 31, you can cancel, and return to original Medicare and enroll in a stand-alone prescription drug plan (Medicare Part D). If you have a PFFS, then you must obtain written permission. You may also be using this Special Election Period if you are switching from one Medicare Advantage plan to another Medicare Advantage plan. You can do this once a year.

Five Star Plan: If you want to switch to a Medicare Advantage plan that is rated as “five star” by the CMS, then you qualify, without calendar restriction. You can switch to a five star plan once, and only once, during a calendar year.

Special Circumstances: There can be special circumstances which occur, and the CMS may grant a limited Special Enrollment Period.[4]

A general rule of thumb: If you qualify for an SEP, then you have 2 months from the date that you begin an SEP to adopt a new plan, whether that is another Medicare Advantage plan, or a new Medicare Part D plan, regardless of the reasons listed here.

Types of Medicare Advantage Plans

There are a dizzying number of different types of Medicare Advantage plans. Frequently, the same insurance company will offer clients multiple options. This book will refer to the entire set as Medicare Advantage, or MA. This includes plans in which prescription drug coverage is included, known as Medicare Advantage Prescription Drug plans. Here are the different types of Medicare Advantage plans:

- HMO (Health Maintenance Organization)
- HMO-POS (HMO Point of Service)
- PPO (Preferred Provider Organization)
- PFFS (Private Fee-for-Service)
- HMO-SNP (Special Needs Plan)

Each type of Medicare Advantage will differ slightly, and each has some distinctive characteristics.

Health Maintenance Organization (HMO): You will need to specify a Primary Care Physician (PCP), who will refer you to specialists as necessary. All providers must be in the network. If you obtain routine medical care from out-of-network medical providers, the HMO may not pay any benefits, and you will be responsible for the entire cost. If you use an out-of-network provider, then you will be responsible for 100% of the cost, and those charges will not count towards the health deductible or the annual out-of-pocket limit. HMOs can be offered with and without prescription drug benefits. In some states, there is a partial rebate of the Medicare Part B premium that accompanies your participation in certain HMOs.

Point of Service (HMO-POS): You will need to specify a Primary Care Physician (PCP), who will refer you to specialists as necessary. If you seek medical attention from those inside the network, then your PCP will coordinate benefits and administer the cost-sharing terms as a courtesy to you. In certain circumstances, an HMO-POS plan will allow you to seek treatment from a provider that is outside the network.

Preferred Provider Organization (PPO): You do not need to select a Primary Care Physician. You can seek medical services from providers outside the network, but with a different, higher cost sharing arrangement. Generally, the number of medical providers that accept a PPO is greater than the number that accepts an HMO (of the same insurance company). Prescription drug benefits are frequently included in these plans.

Private Fee-for-Service (PFFS): You can use a medical provider of your choice, but that provider must accept Medicare assignment of benefits, which means that it must accept Medicare's allowed charge as full payment. As a result, there is no possibility of Part B Excess Charge under this plan. However, a provider has the choice to accept you on a case-by-case basis, except in emergencies. This means that if you go to a doctor for one illness, and you are accepted, that does not guarantee that the same doctor must accept you the next time you attempt to receive services from that medical provider. PFFS plans may, or may not, include prescription drug benefits. PFFS is the only Medicare Advantage plan in which you can purchase a separate, stand-alone prescription drug plan (Part D). Lastly, if you attempt to cancel your PFFS by using a Special Election Period (SEP), you must request permission in order to do so.

HMO-SNP (Special Needs Plan): There are three general types of HMO-SNPs. The first is when you have a chronic illness. The second is when you are resident in a skilled nursing facility. The third is when you qualify for both Medicare and Medicaid (otherwise known as Dual-Eligible SNP or D-SNP). You must qualify to enroll in these plans. You will need to select a primary care physician (PCP), and depending on the SNP, there will be specific types of formularies for your specific chronic illness, if that is the basis of acceptance to the HMO-SNP.

Under a D-SNP, you will almost certainly need to have a case worker assigned to you by the Department of Health and Human Services and the Social Security Administration. In addition, an insurance company will most likely appoint its own individual assistant in order to coordinate benefits. The level of assistance granted is extremely complicated and depends on your net worth and income.

All medical services must be administered by providers in the HMO's network. If you receive services from a non-network provider, then you must pay the entire bill. Medicare will not pay and your HMO-SNP will also not pay.

Medicare Advantage Prescription Drug Plans

Medicare Advantage Prescription Drug Plans combine health insurance with prescription drug coverage in one plan. Some of the different types of Medicare Advantage plans listed in the previous section can also be an MAPD. For example, a Medicare Advantage plan, which is also an HMO, may or may not include prescription coverage.

Important fact: If you have a Medicare Advantage or an MAPD plan, you cannot have a separate, additional stand-alone Prescription Drug Plan (Part D). The exception to this is PFFS, in which case you can have a separate PDP. If you elect a Medicare Advantage that does not include prescription benefits that is ruled as creditable coverage by the Medicare system, then you will have to pay for prescriptions entirely from your own funds. In addition to this, you will be subject to the enrollment penalty at the time that you do enroll in a stand-alone Medicare Part D (prescription drug plan), or a Medicare Advantage plan that does include prescription benefits.

Medicare Advantage Has Improved
Since the first edition of Maximize Your Medicare in 2013, the most dramatic change to Medicare has been the improvement in Medicare Advantage, and specifically, prescription drug coverage within Medicare Advantage plans has been greatly improved. It is entirely possible that the prescription drug costs within Medicare Advantage is superior to benefits provided by standalone prescription drug plans (Part D).

This Happens

Insulin-dependent diabetic has multiple medications and is enrolled in Medigap along with Part D. Copays of medications puts the diabetic into the Part D coverage gap. However, he locates a Medicare Advantage Prescription Drug plan in which the specific insulin he uses is categorized as a Tier 2 generic. The copay for that generic: $0.

This Happens.
Premiums
Medicare Advantage plans may have a monthly premium, which must be paid above and beyond the Medicare Part B monthly premium. In most states, there are multiple Medicare Advantage plans where the premium is $0/month. In a few cases, the premium is effectively negative, because a rebate to your Social Security benefits is made. None of this is a misprint: money can be paid back to your Social Security benefits, which makes the Medicare Advantage plan a “negative premium” plan. Note that you cannot receive financial assistance towards your Part B premium and receive this extra amount. You must actually pay for your Part B premium in order to receive these extra funds.

Medicare Advantage plans will have a number of payment options, including taking a deduction directly from your Social Security payment, a coupon payment book, automatic bank deduction, a deduction from your Railroad Retirement Board check. Some plans may allow you to pay via credit card.

If you rely on Medicaid or state assistance, it may be entirely possible that you can receive assistance to defray the costs of the Part B premium and the premium of an MA/MAPD. A person should check with their case worker to see if he/she is eligible for this assistance.

Deductibles and Coinsurance
Each Medicare Advantage plan will have its own cost-sharing arrangements, a plan-specific set of terms and conditions. Those terms and conditions can require a certain schedule of payments for office visits (other than the preventative care checkup, which is complimentary under the Affordable Care Act), hospital stays, skilled nursing care facilities, durable medical equipment, and everything else under Medicare Part A and Part B.

The deductible, coinsurance and copayment amounts must be fully detailed in your Summary of Benefits guide, and that the coverage that you receive in a Medicare Advantage or MAPD must be at least as good as the benefits that you receive under original Medicare. Lastly, there will be an annual out-of-pocket maximum amount. That annual out-of-pocket amount does not include amounts charged above the Medicare “allowed charge.” The Medicare “allowed charge” has been described in Chapter 3. Certain Medicare Advantage plans address this by disallowing providers from charging any additional amounts to Medicare Advantage beneficiaries.

All Medicare Advantage plans have received official approval from the CMS (Centers for Medicare & Medicaid Services). The cost sharing terms and conditions have been approved by the Centers for Medicare & Medicaid Services (CMS). The reason this is important? The information is true, it must be. Confusion over bills are likely

to be the result of misunderstanding, or administrative error. The probability of the carrier intentionally not fulfilling its financial obligations is zero for all practical purposes.

In-Network vs. Out-of-Network

The most important aspect of Medicare Advantage (MA) coverage is the concept of network. Most people have experienced a network of some sort, whether that is in the form of your employer's group health insurance plan, or private health insurance. For Medicare Advantage, a similar concept applies. When you receive services from providers inside the network, cost sharing is reasonable. Outside the network, however, cost sharing greatly increases the out-of-pocket deductibles, copays, and annual out-of-pocket maximums. That is why it is important to check the physicians that you visit, as well as those that you might be reasonably expected to visit.

Doctors may or may not accept a particular Medicare Advantage plan; do not presume that your doctor will accept your Medicare Advantage plan, even if he/she accepted your employer's plan in the past, and even if he/she accepted insurance from the same carrier before you were under Medicare. Medicare networks can be entirely separate, and you need to check this for yourself (or with an agent's assistance).

HMOs, in particular, deserve very specific examination, because in many cases, you can only go to a specialist after receiving a referral from your primary care provider (PCP). That specialist must also belong to the network.

For PPOs, out-of-network providers will accept any Medicare Advantage plan, but you will be charged a different amount for services received. In addition, the annual out-of-pocket maximum is notably higher if you use out-of-network providers.

One thing that you must keep in mind is that if you travel on vacation, and you require medical attention, then that provider may or may not be inside the network. It is important to note that certain, nationally-prominent insurance companies will allow much wider access of doctors, hospitals and clinics to be noted to be "in network." This is one area that Medicare Advantage carriers have improved. While the improvement in networks does not completely eliminate your responsibility to double-check, and there are challenges that remain, the situation here has improved greatly.

This Happens: Surprise Medical Bills

If you are in a hospital, you may require some diagnostic services or a specialist may be called in order to provide additional services. You may receive a bill for these services, and depending on the type of Medicare Advantage plan that you have, you may receive a nasty surprise.

If the lab or specialist is out of network, then your out-of-pocket expenses may either be higher than expected, or you may be responsible for 100% of the costs.

PPO: In this instance, the healthcare provider can be in-network, which would result in the lowest copay to you. Or, the healthcare provider can be out-of-network, and you would be responsible for a higher copay amount. In addition, the annual out-of-pocket maximum will likely be higher for you, because there is a higher out-of-pocket maximum limit when you use both in-network and out-of-network providers.

HMO: In this instance, the healthcare provider, then you may be responsible for 100% of the costs, if the lab or specialist is not in-network.

This type of situation has received a great deal of public attention. There is a movement, and a proposed legislation to reduce or eliminate this situation. As of this writing, This Happens.

This Happens: Snowbirds

A “snowbird” (a person that goes to warm weather locations during the winter) may vacation for extended periods of time. However, when that person goes to his/her physician in Arizona (or Florida, etc), the physician may not belong to the network, and the out-of-network cost sharing arrangement would apply. The price differential can be so great, that it would have justified more comprehensive coverage via another selection. This Happens.

Not all insurance companies are equal, of course. Some are far more dominant in particular states, or in your particular location. Others are more national in scope and scale. You should think carefully if you are going to choose a Medicare Advantage plan and check your medical providers in advance in order to minimize your out-of-pocket costs. Most of the time, the insurance companies have online directories, so you can search for your providers, or you can ask your insurance representative/agent for assistance.

In addition to that, you will be faced with a very complicated situation with respect to annual out-of-pocket maximums if you are enrolled in a Medicare Advantage plan. The reason this occurs is because some of your expenses will be in-network, and some will be out-of-network. You will need to keep track of your visits, and the charges, in order to reconcile the statement of benefits that you receive from the insurance company that issued your Medicare Advantage plan. That alone is the source of great confusion because then you will basically be forced to verify your Medicare Advantage’s records by comparing them to bills received.

Annual Notice of Change (ANOC)

Every year, both Medicare Advantage plans and standalone prescription Plan (Part D) beneficiaries will begin to receive an annual notice of change, a regulatory requirement mandated by the CMS. The ANOC will contain detailed information regarding coverage you have received in the current year and will display how it will change in the following year. For example, the ANOC will display changes in premiums, deductibles, and copays, which may vary from year to year, depending on the services that you receive.

It cannot be overstated: beneficiaries should read these ANOCs when received. Too often, beneficiaries discard this document, and learn, after the fact, that their out-of-pocket costs change at a time they least expect. A very important feature about ALL Medicare Advantage and Medicare Part D plans is that they are annual contracts, these plans are approved by the CMS on an annual basis and can be greatly affected by a large number of factors.

Last (and not least), the carriers of Medicare Advantage Plans and Part D plans are actively competing against one another. The result is that the terms and conditions of your Medicare Advantage or Medicare Part D are likely to change, and those changes can affect the cost of the coverage and services you receive.

How to Compare Medicare Advantage Plans

The improvements in Medicare Advantage, since the first edition of Maximize Your Medicare, have been dramatic. Networks have expanded, access to specialists can occur with referral, prescription drug benefits can exceed standalone Part D plans, health and prescription deductibles can be as low as $0.

If anything, this has made it more difficult to tell exactly which Medicare Advantage plan is best.

Deductible. The stunning development in 2019 is the continued evidence of lower health and drug deductibles among Medicare Advantage plans. There are now Medicare Advantage plans with health deductibles $0, and plans with drug deductibles which are dramatically lower than the federal standard of $415.00. This is very valuable to the millions of people who live on a fixed monthly income. This allows people to plan their monthly spending budgets carefully, especially at the beginning of the year.

Part B Premium Rebate. For enrollees in certain Medicare Advantage plans, a portion of the Part B premium ($135.50 a month for new enrollees) can be rebated, in the form of a higher Social Security benefit. It is

important to note that those that receive governmental assistance for Part B premiums, resulting from Medicaid payments, are not eligible.

Prescriptions. As noted earlier, the improvement to prescription drug benefits has been dramatic and yet, it will very much depend on your specific prescriptions. It is entirely the case that the selection of Medicare Advantage plan will depend on the overall estimated cost of prescriptions. That is especially the case since the remainder of factors in this section are very competitive, that there can be virtually no difference. However, the same cannot be said about prescription drug benefits, and that means that this is an area that can determine which Medicare Advantage plan is best.

Hospital stay copay. There are two ways that most Medicare Advantage offer cost sharing if you are admitted to the hospital. You should choose the copay that is a given cost per stay, and not the deductible that charges per day. Why is that? Simply put, you usually get admitted to a hospital for longer than a single night. Therefore, when you multiply the per day copay times the number of days, that is usually more than the copay that is charged by those plans that charge on a per stay basis. All else equal, the premium will, on average, be slightly higher, but the fact is that if you stay at a hospital for multiple days, then you will save money by choosing a Medicare Advantage plan that charges you per stay, and not on a per-day basis.

Office visits. If there is a plan that does not distinguish between your family physician and a specialist, then that should be chosen, since an office visit to a specialist may be substantially more expensive than an office visit to your family doctor.

Extra benefits. Many Medicare Advantage plans include discounts on dental and vision, weight-loss, and smoking cessation programs. Extensive, specialized dental work, such as implants, or treatment of gum disease, are generally not covered by these extra benefits. In fact, as many know, serious dental work is usually uncovered by any type of dental insurance, and the maximum benefit is limited.

In 2018, the rules for the types of extra benefits allowed under Medicare Advantage have been relaxed. This means that there are now benefits for in-home shower bars, etc. It is complicated, but this particular area has the potential to entirely change the health insurance landscape, because if that benefit can be proven to lower healthcare costs overall, they may be offered as additional benefits to Medicare Advantage policyholders.

The pressure on the Medicare system has resulted in the elimination of certain treatments, consultations, or limited the inclusion of others. One type of treatments being limited is chiropractic treatments. Certain Medicare Advantage plans cover chiropractic services, which original Medicare does not. Certain Medicare Advantage plans provide benefits for physical therapy above and beyond original Medicare.

Notably, observation status has already been addressed by certain Medicare Advantage plans. You can recall Chapter 2, where the principle of “Observation Status” is addressed. Under original Medicare, an inpatient status is required, and that stay must be for three days, in order to receive Skilled Nursing Care benefits under Medicare Part A. However, some carriers have altered this in a very positive way, because beneficiaries of certain Medicare Advantage plans can receive Skilled Nursing Care benefits without a 3-day inpatient hospital stay.

Five-Star Plans. The CMS rates plans every year. It is beyond the scope of this book to discuss how it reaches its determination. The plans are given a number of stars between 1 and 5. You can switch into a plan that has been given five stars by the CMS at any time during the year. This is a new Special Enrollment Period (SEP). You can switch into a five star program once, and only once, during a calendar year.
Money Saving Tip #1 Medicare Advantage

There is the age-old saying, “You get what you pay for.” Well, when it comes to Medicare Advantage, there is a new twist, and it goes, “You don’t always get what you pay for, but you always pay for what you get.” What in the world does this mean? It means that if you compare carefully, side-by-side (apples to apples, whatever), then you can find, even within the same company, that you can save premium, without a substantial decline in benefits. Maybe you have the time to compare by yourself, or maybe you know an expert, or a professional.

If you read the previous section, then you will find that you can obtain policies with similar out-of-pocket expenses and save $30-$50 a month. Maybe you think that isn’t very much money. Now start multiplying by years and you will see the figures quickly increase.

Anecdotally, people don’t like change. They stay with the same plan if things do not change dramatically within their own plan. However, you need to remember that there is intense competition among insurance companies. You should absolutely use that to your advantage.

Academic studies have concluded that consumers leave 10% a year in cost on prescription drug plans due to this behavior (lack of changing to more efficient plans). Anecdotally, this also occurs when it comes to Medicare Advantage plan selection. If anything, 10% savings is an underestimate: the total estimated costs, can differ by thousands of dollars, every year, among plans.

Of course, there are limits to this point, i.e. it is not the recommendation of Maximize Your Medicare that you change physicians every year in order to accommodate your Medicare Advantage plan. Nevertheless, not shopping around will cost you money, or benefits, or both.

Extra Help and Medicare Advantage
If you receive Extra Help, which is the federal assistance program to help pay for prescription drug benefits, then your Extra Help assistance may, or may not, affect the published Medicare Advantage premium. Every year, the allocation towards your Medicare Advantage premium is subject to change. The results will differ from plan to plan, from year to year.
Hint: when researching plans on Medicare.gov Plan Finder, be sure to select “I applied for and got extra help from social security.”

Notes

1 When the words “on average” are used, one should be careful. This relates to the term called “actuarial equivalent.” While the overall Medicare Advantage plan must meet or exceed the average terms and conditions of original Medicare, certain clauses can differ from original Medicare.

2 There is an exception here, because if John Smith changed his mind before turning the age of 65.5, then he would be approved for Medigap under Medigap Open Enrollment rules, under which there is no medical underwriting.

3 There are exceptions. See “State-Specific Rules.” In New York and Connecticut, this is the period of time when a person can enroll cancel Medicare Advantage, select a Part D plan, and enroll in Medigap. The applicant can do so because there are no underwriting requirements for acceptance.

4 A prime example is that the CMS extended the Annual Election Periods for those affected by the effects of hurricanes, and disruption caused by the wild fires in California. In this instance, evidence will need to be provided that you qualify. Another example is if the Medicare Advantage plan is cancelled by the CMS due to financial difficulties at the carrier.