Helping Older Adults Resolve Legal
& Long-Term Care Problems
& Fight Medicare Fraud

Medicare Advantage Plans (Part C)

1. What is the Difference between Original Medicare and Medicare Advantage Plans?

Original Medicare consists of Part A Hospital Insurance and Part B Medical Insurance. Both Part A and Part B have a deductible and Part B has a monthly premium and a 20% copayment for many services. However, you can go to any hospital and see any doctor in the United States who takes Medicare. You can consider purchasing a Medigap Supplemental Plan to cover health care costs not covered by Original Medicare. You also have the option to buy a separate Part D plan to cover prescription drugs. Pro Seniors has more information about Part A, Part B, Medigap Insurance, and Part D plans in our Fact Sheets on these topics.

Instead of staying on Original Medicare, you could elect to join a Medicare Advantage Plan ("MAP"). MAPs are offered by private insurance companies that contract with the Federal government. MAPs are required to provide all of your Part A and Part B benefits and they have the option to offer supplemental coverage beyond what Part A and Part B cover, such as some vision, hearing, and dental services. Copays for services may be higher or lower than Original Medicare. You should carefully review your MAP's Plan Documents concerning copays. Some types of MAPs have limited provider choice. MAPs may have a yearly limit on out-of-pocket cost. While plans may advertise that they are "premium free," check the fine print because this typically means that you still pay the same Part B premium as Original Medicare, just not an additional premium. MAPs often bundle in Medicare Part D prescription drug coverage.

While MAPS are supposed to cover the same services as Original Medicare, the Federal government has found MAPs delay or deny access to services, even though coverage requests met Medicare coverage rules. If this happens to you, make use of your appeal rights as discussed later in this fact sheet.[1]

2. Does a Medicare beneficiary have to enroll in a MAP?

No. A Medicare beneficiary may elect to stay in Original Medicare simply by not enrolling in any of the MAPs offered. [2]

3. What Types of MAPs are Available?

(1) A Health Maintenance Organization (HMO) – If you join an HMO, you generally must get care and services from doctors, providers and hospitals in your MAP's network. You usually need a primary care physician and referrals to see a specialist. However**,** Medicare HMOs are required to cover emergency and urgent care services and out-of-area dialysis even if non-network providers provided the care. If you want drug coverage, you should join an HMO that offers it because you usually cannot get a separate drug plan.

(2) Preferred Provider Organization (PPO) – If you join a PPO, you can go outside the network of health care providers and will still cover at least part of the cost of that provider's care. However, you pay less if you use health care providers in the network. If you want drug coverage, you should join a PPO that offers it because you usually cannot get a separate drug plan.

(3) Private Fee-for-Service Plans (PFFS) – A PFFS determines how much you pay doctors, health care providers, and hospitals. If the plan has a network of health care providers and you go to an out-of-network provider that accepts the plan's terms, you may pay more. If your plan does not offer prescription drug coverage, you can get a separate drug plan.

(4) Special Needs Plans (SNP) – A plan that limits membership to people with specific diseases or characteristics. Some are HMOs and some are PPOs. These plans tailor their benefits, provider choices, and drug formularies to best meet the specifics needs of the groups they serve. All SNPs must provide prescription drug coverage.

(5) HMO Point of Service (HMOPOS) – A type of HMO plan that may allow you to get some services out-of-network for a higher cost.

(6) Medical Savings Account (MSA) – A plan that combines a high deductible health plan with a bank account. The plan deposits money into the account. You can use the money to pay for your health care services during the year. There is generally no provider network and you can join a separate drug plan.

Careful attention must be paid to the different benefits and costs offered by each choice, and some choices are not available in all regions or states. [3]

4. Who can enroll in a MAP?

Generally, you must be entitled to Part A and enrolled in Part B of the Medicare program and live in the geographical area served by MAP. [4]

5. Does a beneficiary have a right to appeal a medical decision by a MAP organization or one of their providers?

Yes. You, your provider, your representative, or the legal representative of your estate if you are deceased can appeal an adverse determination by a MAP. You can appeal a

decision by a MAP refusing to provide a service or you can appeal the amount that the MAP says you must pay for a service. You can appeal a MAP's refusal to pay for out-of-the-area emergency services, urgently needed services, dialysis, or post-stabilization care. You can also appeal the reduction or discontinuation of previously authorized treatment. And you can appeal the failure of the MAP to timely cover health care services or to timely provide you with notice of an adverse determination when their delay adversely affects your health.

There are five levels of appeal from a MAP's initial determination: (1) reconsideration by the MAP, (2) review by an Independent Review Entity, (3) hearing with an administrative law judge at the Office of Medicare Hearings and Appeals, (4) Medicare Appeals Council, (5) Federal District Court. The only step where appeal is automatic is appeal step 2: if reconsideration is denied your appeal will be automatically sent to the Independent Review Entity. At every other step, including starting the appeal by requesting reconsideration, you have as little as 60 days from the date on the notice to submit an appeal to the next step. [5]

6. How do I start the appeal process?

To start the appeal process by requesting reconsideration, you, your representative or your doctor can file a request to your MAP within 60 days of the date of the determination you are appealing which includes this information:

(1) Your name, address, and the Medicare number on your Medicare card;
(2) The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
(3) If you've appointed a representative, such as a family member, friend, or doctor, include the name of your representative and proof of representation.
(4) Any other information that may help your case. You can ask your health care provider for documents or information that will help your case.

You should keep copies of everything you send your MAP as part of your appeal. If you do not know where you should send your appeal, you can ask your MAP or call the Ohio Senior Insurance Information Program at 1-800-686-1575 or at OSHIIPmail@insurance.ohio.gov. If you have questions about how to appoint a representative, you can call Medicare at 1-800-633-4227; TTY 1-877-486-2048. [6]

7. What if I need an immediate decision?

You, your representative, or your physician can request an expedited decision if the usual time of 14 days for an initial organizational determination could seriously jeopardize your life, health or ability to regain maximum function. If the MAP approves your request for expedited determination, it will make a decision within 72 hours. Expedited determinations concerning Part B covered drugs must be made in 24 hours. If the MAP refuses your request for expedited determination, it must notify you and explain how you can file an expedited grievance if you disagree with the MAP's decision not to expedite. If the MAP decides your expedited determination request and the decision is not completely favorable to you, the MAP must explain to you both the

standard and expedited processes for requesting reconsideration and the rest of the appeal process. [7]

8. How much of my hospital stay will a MAP pay? Am I protected from Surprise Bills?

MAPs are required to cover medically necessary hospitalizations when they would be covered by Original Medicare. However, if you are in a MAP that has a network, you may be required to go to an in-network hospital or you could pay more if you go to a hospital that is out-of-network. You may need to obtain prior authorization for non-emergency hospitalization from your MAP.

Your out-of-pocket cost will depend on your MAP's hospital deductible and co-payment policy for that year. For example, one MAP may charge $350 a day for each day of hospital care up to a maximum of $2500 per year, while another one may charge a flat $400 for each hospital stay in a calendar year. It is crucial that you review your hospital deductible, co-payment and maximum co-payment policies when selecting a MAP.

When you go to an emergency room and you have a MAP, the No Surprises Act protects you from unexpected out-of-network charges for emergency services from the hospital, providers giving you care at the hospital, and air ambulance providers. You still have to pay your normal cost-sharing, including copayments, coinsurances, and deductibles.

If you are seen by an out-of-network provider at an in-network hospital, hospital outpatient department, or ambulatory surgical center, you are protected from additional out-of-network charges. These protections do not apply at other facilities like doctor's offices, out-of-network facility, or to ground ambulance services, vision-only and dental-only insurance, short term limited duration and health care sharing ministry plans, fixed indemnity excepted benefits plans.

You could lose your protection from out-of-network surprises if you sign a Notice and Consent form. Signing the form means that you agree to get care out-of-network and give up your protections from unexpected out-of-network bills. **To save money, do not sign the form.**

You cannot be asked to sign a Notice and Consent form and give up your right to pay in-network costs for emergency care or for items and services furnished because of unforeseen urgent medical needs that arise when an item or service is furnished. You cannot be asked to sign if there is no in-network provider available to provide items and services. You can be asked to sign the form for post-stabilization services. Before you sign or if you have questions or a complaint, you can call the No Surprises Help Desk at 1-800-985-3059. [8]

9. What if my MAP organization wants me discharged from a hospital and says that I will have to pay for all additional care?

All hospitals must provide you with an Important Message from Medicare which tells you your hospital discharge appeal rights, as well as with an initial discharge notice if the

hospital decides to discharge you. If you think that Medicare covered services at a hospital is ending too soon, you can request a fast appeal. Your provider's Notice will explain how to ask for a fast appeal. You can contact Livanta, for help appealing at 1-888-524-9900 or TTY: 1-888-985-8775. You may also need to start a separate appeal for any other services you received after the decision to end services.

If you wish to appeal, contact Livanta requesting expedited determination by telephone or in writing no later than midnight of the day of discharge and then make yourself or your representative make yourself available to discuss the case with Livanta. If you do this, then other than your coinsurance and deductible, you will not be personally responsible for inpatient hospital services you receive before noon on the date you receive written or oral notification of the expedited determination. If you request an appeal after the midnight deadline, you may be held responsible for charges incurred after the date of discharge or as otherwise stated by the QIO. [9]

10. What if a Medicare beneficiary decides that they no longer wants to be in the MAP organization?

Medicare beneficiaries already enrolled in a MAP can disenroll from the MAP and return to traditional Medicare or switch from one MAP to another by submitting the appropriate forms to their MAP organization or by calling Medicare at 1-800-633-4227 or TTY 1-877-486-2048 during the open enrollment period of October 15 through December 7 and the open enrollment period of January 1 through March 31. Sometimes, depending on special circumstances, a beneficiary becomes eligible for a special enrollment period where they can make changes outside of the open enrollment periods. Call Medicare to see if you qualify for a special enrollment period. [10]

11. How can I find and compare Medicare Advantage Plans?

Not all Medicare Advantage Plans work the same way. Before you join, you can find and compare Medicare plans in your area by visiting Medicare.gov/plan-compare or calling Medicare at 1-800-633-4227 or TTY 1-877-486-2048. You can also contact the Ohio Senior Insurance Information Program at 1-800-686-1575 or at OSHIIPmail@insurance.ohio.gov.

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Pro Seniors' Legal Helpline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the helpline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Helpline or consult an attorney in elder law.

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Endnotes:

[1] Centers for Medicare and Medicaid Services, *Costs*, available at https://www.medicare.gov/basics/costs/medicare-costs (accessed March 25, 2024); Centers for Medicare and Medicaid Services, *Medigap (Medicare Supplement Health Insurance)*, available at https://www.cms.gov/medicare/health-drug-plans/medigap (accessed March 25, 2025); Centers for Medicare and Medicaid Services, *Compare Original Medicare & Medicare Advantage*, available at https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage (accessed March 25, 2024); Centers for Medicare and Medicaid Services, *Medicare Advantage Plans cover all Medicare services*, available at https://www.medicare.gov/medicare-advantage-plans-cover-all-medicare-services (accessed March 25, 2024); U.S. Dept. of Health and Human Services, *What is Medicare Part C?*, available at https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-c/index.html (accessed March 25, 2024); U.S. Dept. of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denial of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (April 2022), available at https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf. *See also* 42 U.S.C. §§ 1395w-21–1395w-28; 42 C.F.R. §§ 422.1–422.2615.

[2] *See* 42 U.S.C. § 1395w-21(a)(3); 42 C.F.R. § 422.50(a)(1), (a)(3)).

[3] 42 C.F.R. § 422.4; 42 C.F.R. § 422.113; 42 U.S.C. § 1395w-28(b); Centers for Medicare and Medicaid Services, *Compare types of Medicare Advantage Plans* (accessed March 26, 2024), available at https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/compare; Centers for Medicare and Medicaid Services, *Your health plan options* (accessed March 26, 2024), available at https://www.medicare.gov/sign-upchange-plans/types-of-medicare-health-plans/medicare-advantage-plans.

[4] 42 C.F.R. § 422.50; 42 U.S.C. § 1395w-22(b); 42 U.S.C. § 1395mm(c); 42 C.F.R. § 422.66(d).

[5] 42 U.S.C. § 1395w-22(g)(2); 42 C.F.R. §§ 422.560–422.626; Centers for Medicare and Medicaid Services, *Medicare Managed Care Appeals & Grievances* (accessed March 26, 2024), available at https://www.cms.gov/medicare/appeals-grievances/managed-care; Centers for Medicare and Medicaid Services, *Medicare Managed Care (Part C – Medicare Advantage)* (accessed March 27, 2024); https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-.pdf

[6] Centers for Medicare and Medicaid Services, *Medicare health plan appeals - Level 1: Reconsideration* (accessed March 27, 2024), available at

https://www.medicare.gov/claims-appeals/file-an-appeal/medicare-health-plan-appeals-level-1-reconsideration; Centers for Medicare and Medicaid Services, *5 things to know when filing an appeal*, (accessed March 27, 2024); https://www.medicare.gov/claims-appeals/file-an-appeal/5-things-to-know-when-filing-an-appeal.
There are a few ways to appoint a representative, which are described here: Centers for Medicare and Medicaid Services, *Can someone file an appeal for me?* (accessed March 27, 2024), available at https://www.medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me.

[7] 42 C.F.R. § 422.566(a), (c); 42 C.F.R. § 422.568(b)(1); 42 C.F.R. § 422.570; 42 C.F.R. § 422.572.

[8] 42 C.F.R. § 422.101(a); Centers for Medicare and Medicaid Services, *Understanding Medicare Advantage Plans* (accessed March 27, 2024), available at https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf; 45 C.F.R. §§ 149.10–149.450. Centers for Medicare and Medicaid Services, *Know your rights when using health insurance* (accessed March 27, 2024), available at https://www.cms.gov/medical-bill-rights/know-your-rights/using-insurance.

[9] 42 C.F.R. §§ 405.1205–405.1206; 42 U.S.C. § 1395cc(a)(1)(M); 42 C.F.R. § 482.30(d)(3); Centers for Medicare and Medicaid Services, *Getting a fast appeal in a hospital* (accessed March 27, 2024), available at https://www.medicare.gov/claims-appeals/your-right-to-a-fast-appeal/getting-a-fast-appeal-in-a-hospital.

[10] 42 U.S.C. §1395w-21(c)(2)(B); 42 C.F.R. § 422.66(b); 42 C.F.R. § 422.62.