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Important to consider options when choosing among Medicare plans

Medicare Advantage plans, or Medicare Part C, are plans offered to Medicare beneficiaries as an option to traditional fee-for-service Medicare. Traditional Medicare Part A is available at no cost to beneficiaries who qualify as the result of age or disability status. The premium for Part B is deducted from the beneficiary's Social Security check each month. Part B is available to all qualified beneficiaries, but requires affirmatively opting for this benefit. Medicare Part A, although an entitlement benefit, has limitations in its coverage. For instance, Medicare Part A covers hospital costs, but there is a $952.00 deductible. For this reason, most beneficiaries with traditional fee-for-service Part A also purchase a supplemental insurance to provide the most complete coverage.

Medicare Advantage plans (formerly known as Medicare+ Choice plans) offer an option to the purchase of a supplemental Medicare insurance plan. Medicare Advantage plans can be HMOs or PPOs, and require a monthly premium. However, the monthly premium is generally lower than that of a supplemental plan. This is appealing to those beneficiaries who are on a limited income, and find the premiums for most supplemental plans to be beyond their means. Since these plans are private, there can be advantages to the beneficiary in terms of lower cost sharing and additional benefits, as well as the advantage of the lower premiums.

It is important to realize, however, the disadvantages of these types of plans. Many plans require selection of a primary physician, who may not be the same as your current doctor. Visits to other doctors will often require a referral to be obtained. Co-pays for doctor visits are often imposed. And because these plans save money by managing the beneficiary's care, limits on hospital and nursing home stays are common. The nursing home issue can be significant, since traditional fee-for-service Medicare generally pays for the first 20 days of long term nursing care following a 3 day hospital stay, and admission to a facility for rehabilitation. The beneficiary who also has a supplemental plan may quality for an additional 80 days of service provided that certain guidelines are met. Those beneficiaries with a Medicare Advantage plan, such as Keystone 65, may be approved for a limited stay, such as 5 days.

Furthermore, a recent article by the Commonwealth Fund (www.cmwf.org) stated that out-of-pocket costs for Medicare advantage plan enrollees during 2005 varied widely, depending upon health status. Plan members in good health may have spent $100 in out-of-pocket costs, while those in poor health averaged $6,000 in out-of-pocket expenses. These plans are often not a better deal for sicker beneficiaries who use more health services.

On the other hand, for healthier beneficiaries, the average monthly premium for Part D portion of Medicare Advantage plans nationwide is $19 per month. This compares to Part D stand alone prescription plan premiums, which average $24.75 in Pennsylvania, and up to $37 per month across the country. However, low income beneficiaries in Pennsylvania have the advantage of access to the PACE and PACENET programs for drug coverage. The savings on the drug premiums may not be as big an advantage in our commonwealth.

The message is to consider all options carefully before choosing a Medicare plan. Health status is important to consider, as well as ability to financially manage premiums for a supplemental plan. Sicker beneficiaries may not have as many options as those who are well.