

Understanding Medicare

Many are confused when choosing between Original Medicare with a Supplement and a Medicare Advantage plan.

Here is a simple explanation.

Medicare regulates both plans. However, the plans operate under different management rules.

A Medicare Advantage plan is administered by a private (usually for-profit) insurance company. The insurance company assumes the risk for paying a member's claims. They receive a set amount from the federal government (about \$12,000), the plan sponsor, and a premium paid by the member. From that amount, they must pay the members' claims. Money remaining beyond what is paid out for claims goes to the insurance company for administration and profit.

A Medicare Supplement plan is one that "supplements" amounts paid by Original Medicare. The federal Medicare program pays the majority of the cost (usually 80%) of the Medicare Eligible Amount with the Supplement plan picking up the remaining 20%. Medicare pays first. Thus, the majority of risk for large claims is on the federal government, not the Supplement administrator.

Under the Supplement plan, decisions about care are agreed upon through the traditional Medicare program. Original Medicare usually has fewer pre-certification rules than most Medicare Advantage plans and therefore allows you and your doctor more flexibility to manage your care.

You will hear it stated that Advantage plans must follow Medicare rules but it is important to understand that Medicare Advantage plans (privatized Medicare) have more discretion to set their own pre-certification rules surrounding what care is approved for payment. This allows Medicare Advantage plans to have more "say" in how you and your doctor can manage your care. The approvals can be required in advance of treatment. Many experts conclude that your care is more "managed" by the *insurance* company within Medicare Advantage compared to Original Medicare with Supplement programs, where your care is determined more by your doctor and you.

Medicare underpins the entire system

Original Medicare has done research to establish how much most procedures, tests and equipment cost. Then they have determined an approved rate that (with reasonable profit) providers can charge. This is called the “Medicare Approved/Eligible Amount”.

Second, Original Medicare has established a national program which includes doctors that accept the Medicare assigned prices. This is called accepting “assignment”. The vast majority of hospitals and doctor’s practices throughout the country accept Medicare assignment. Public and University Hospital systems that take public funds are also *required* to accept Medicare. (We are fortunate in Connecticut to have so many excellent choices for care: Hartford Healthcare, the UConn Health system, Yale/New Haven, Trinity Health/St Francis and others.)

Third, Original Medicare sets the requirements for coverage. Most common preventive services, tests and procedures are covered. These services are required by the Original Medicare system to be covered by the Medicare Advantage Insurance companies.

Finally, Medicare payroll tax and government allocations establish and maintain the Medicare Trust Fund that pays most of the bills. The Fund pays 80% in Original Medicare, while administration costs are less than 2%. There is no profit. The Medicare Trust Fund also provides the money (approximately \$12,000 per enrollee per year) to the Medicare Advantage companies to cover the bills. Advantage insurance companies are required by Medicare to spend at least 85% on care coverage, while about 15% goes to administration and profit.

For most retirees, Original Medicare with a Supplement is the system that has established the basic coverage that we depend on medically and financially. Original Medicare’s direct payment structure helps to preserve the Medicare Trust Fund for future patient care.