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.

Original Medicare underpins the entire system

Original Medicare sometimes referred to as Traditional Medicare, has done research to establish how much most procedures, tests and medical equipment cost. Then they have determined an approved rate that (with reasonable profit) providers can charge. This is called the "Medicare Approved/Eligible Amount", a form of cost containment.

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 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, St Francis/Trinity Health.)

Third, Original Medicare sets the requirements for comprehensive coverage. Most common ***preventive*** services, tests and "medically necessary" procedures are covered. These services are required by the Original Medicare system to be covered by all Medicare-based plans, including Advantage plans.

Finally, Medicare payroll tax and government allocations establish and maintain the Medicare Trust Fund that pays most of the bills for seniors. The Fund pays 80% in Original Medicare, while administration costs are less than 3%. Because this is a government program, there is no profit.

The Medicare Trust Fund also provides the monthly money (approximately $12,000 per enrollee per year) to the Advantage insurance companies to cover their enrollee's claims. Advantage insurance companies are required by Medicare to spend at least 85% on care coverage, while about 15% goes to administration and profit.

The Advantage "privatized" insurance plan

A Medicare Advantage plan is administered by a private (usually for-profit) insurance company. The insurance company assumes the risk for paying enrollee claims from the money they receive from upfront sources. They receive a set amount from; 1. the federal government (about $12,000/yr.), 2. a premium paid by the enrollee and, in group plans, 3. the plan sponsor. From that amount, they must pay the "Medicare Eligible Cost" of the enrollee's claim. Money remaining beyond what is paid out for claims goes to the insurance company for administration and profit.

You will hear it stated that Advantage plans must follow Medicare rules, but it is important to understand that Advantage plans (privatized Medicare) have more discretion to set their own pre-certification rules surrounding what care is approved and what doctors “accept their plan”. This allows Advantage plans to have more "say" in how a doctor can manage your care and in some cases, plans pay the doctor less than the “Medicare Eligible Amount”. Your provider must seek approvals in advance of treatment, while some “payment denials” occur after the service. This has lead to a rising number of providers and hospital systems that do not accept Advantage plans, even while they accept Original Medicare.

Many experts conclude that your care is more restricted by the ***insurance*** company within the Advantage plan system compared to Original Medicare, where your care is determined more by your doctor and you, without being subject to insurance company restrictions.

The Original Medicare Supplement

A Medicare Supplement plan “supplements” amounts paid by Original Medicare. The federal Medicare program directly pays the majority of provider claims (usually 80%) of the Medicare Eligible Amount. Then the Supplement plan picks up the remaining 20% and may include all the extras (dental, vision and hearing). Medicare pays your provider first, thus, the majority of risk for large claims is on the federal government, while the Supplement insurance company must honor their contract and pay the lower risk 20%.

Under the Supplement plan, decisions about care are agreed upon through traditional Medicare’s comprehensive, preventive and medically necessary coverage. Medicare has fewer pre-certification rules than most Advantage plans and allows you and your doctor more flexibility to make decisions about your care. You can see any provider who accepts Medicare, nationwide.

Original Medicare is the system that has established the basic comprehensive coverage that we depend on medically, while protecting family finances, benefiting the economy as a whole for the past 60 years. Original Medicare’s direct payment structure with low administration expense and cost containment help to preserve the Medicare Trust Fund for future patient care.

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“ ***NEA Member Benefits believes that the more traditional coverage offered by Medicare combined with a Medicare supplement insurance plan is still the choice that gives you the most freedom.*** *It lets you choose your doctors and hospitals and helps you control your out-of-pocket costs. It lets you remain in control of the management of your care. While some of the other options may appear a little cheaper up front, they can limit your medical care choices and could hit your pocketbook hard if you get seriously ill.”*

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