

HEALTH POLICY
BRIEF
MARCH 2010

Consumer Options When Medicare Advantage Plans Withdraw or Change Their Benefits

SUMMARY

Medicare Advantage Plans, private plan alternatives to traditional Medicare, will likely undergo a lot of changes in the near future. To help keep the Medicare program trust fund from running out of money, the Medicare agency (CMS) and Congress are likely to reduce documented overpayments to Medicare Advantage plans, as well as make other changes designed to improve the quality of their operations. These types of changes will probably be enacted whether or not we get comprehensive health reform. In this brief, we look at how Medicare Advantage plans reacted to past payment changes, and review the rights of seniors should their Medicare Advantage plan raise premiums, reduce benefits, or withdraw from the market.

Why Are Payments to Medicare Advantage Plans Being Reduced?

Medicare Advantage (MA) plans, private plan alternatives to traditional Medicare, will likely undergo a lot of changes in the near future.

Medicare Advantage plans were originally intended as a way to lower Medicare costs. Through competition, flexible design, care coordination and other innovations, they were expected to save an average of 5 percent for each person enrolled.¹ As the program evolved, however, the government's payment rules were relaxed, these private plans ended up getting paid too much. Today, MA plans actually cost an average of 9-13 percent *more* per beneficiary than traditional Medicare spends.² The overpayments average more than \$1,100 for each beneficiary enrolled in a private plan.³

Instead of saving Medicare money, overpayments to the MA plans advance the day when Medicare's Part A (hospital) Trust Fund is predicted to be insolvent by

HOW DOES MEDICARE ADVANTAGE DIFFER FROM "REGULAR" MEDICARE?

Medicare Advantage is an alternative to "traditional" Medicare. The federal government pays private insurance companies who voluntarily run these alternative plans as a means of giving seniors more options. These private plans must cover the same services as Medicare but may use different cost-sharing arrangements. They may also use "restricted" networks of providers, like an HMO. When these plans receive a government payment that exceeds their cost of providing coverage that is "actuarially equivalent" to Medicare, they must provide a rebate to enrollees or include extra benefits like eyeglasses. About 24 percent of the Medicare population is enrolled in these plans. Many enrollees in these plans don't know them as Medicare Advantage because their insurance card uses a different name, like Secure Horizons.

Traditional Medicare consists of several parts: **Part A (Hospital Insurance)** which helps pay for inpatient care in a hospital, skilled nursing facility, or hospice, and for home health care; and **Part B (Medical Insurance)** which helps pay for doctors' services and outpatient care. Prescription drugs are covered through an optional program called **Part D**—a program enacted in 2003 that also uses private insurers. Another optional coverage that seniors can buy is **Medigap** (also known as Medicare Supplemental) plans which help fill in some of the cost-sharing associated with traditional Medicare.

17 months.⁴ In addition, the overpayments raise the cost of the Part B premiums paid by all enrollees.⁵

With or without comprehensive health reform, government payments to Medicare Advantage plans will be reduced so that they more closely approximate the cost of covering those beneficiaries in traditional Medicare. The program simply can't afford these higher payments.⁶

With or without health reform, government payments to Medicare Advantage plans are likely to be reduced.

Every year since 2005, the commission that guides Congress on Medicare policy has recommended that MA payments be brought in line with the costs of the traditional Medicare program.⁷ While Congress has not yet acted on this recommendation, more incremental reforms are already underway. The 2008 Medicare Improvements for Patients and Providers Act reduced payments, strengthened protections for beneficiaries with respect to how MA plans are marketed, and required private fee-for-service (P.F.F.S.) plans to have formal networks of providers in place starting in 2011. In addition, CMS (the government agency that administers Medicare) has been moving administratively to reduce overpayments due to the way plans bill or code the cost of care. Finally, to reduce "clutter" in the marketplace, CMS is encouraging the consolidation of plans with fewer than 100 members.⁸

What Does This Mean for MA Enrollees?

Today, these excess payments translate into extra benefits for MA enrollees and profits for the plans themselves. As prior payment adjustments have demonstrated, MA plans could react to this payment reduction in a number of ways:

- Become more efficient and/or reduce administrative expenses and profits to minimize the impact on beneficiaries
- Charge higher premiums⁹
- Reduce benefits
- Withdraw from the market

This sort of “churning,” in fact, has gone on for years as Medicare Advantage plans react to evolving government requirements designed to address enrollee needs and the long-term financial solvency of the program.

Fortunately, beneficiaries have a guaranteed right to return to traditional Medicare at any time, along with other rights. Below, we examine enrollee options under the four scenarios.

The largest Medicare Advantage plans spend 15 percent of revenues on profits, marketing and other corporate expenses. In contrast, traditional Medicare spends 98 percent of its money on medical care.

Could MA Plans Become More Efficient?

Consistent with the original intent of these plans, several recent reports suggest that MA plans could become more efficient. By tightening up their non-medical spending (such as advertising), they could absorb all or part of the lower government payments without raising premiums or reducing benefits.

Approximately 70% of MA enrollees are in for-profit plans. According to a recent study, in both 2005 and 2006 MA plans earned more profit than they expected to when they prepared their bids for CMS, the Medicare agency.¹⁰ When MA plans take in more profit than expected, this disadvantages enrollees. MA plans are expected to provide extra benefits or reduce out-of-pockets costs, when their payments from Medicare exceed the cost of covering Medicare’s basic services (plus reasonable overhead). Unanticipated profits, however, come too late for extra benefits to be included in the current year’s benefit package.

Overall, Medicare Advantage plans spend fairly large sums on non-medical costs. According to another report, the 34 largest Medicare Advantage insurers spent over 15 percent of revenues (enrollee premiums plus their government payment) on profits, marketing, and other corporate expenses.¹¹ In contrast, traditional Medicare spends 98 percent of its money on medical care.

Furthermore, some MA plans have demonstrated an ability to deliver the Medicare package of services as efficiently as traditional Medicare. In general, long-standing HMO-style plans cover their enrollees at a cost that is the same or cheaper than traditional Medicare.¹²

We conclude that there is room for MA plans to become more efficient but little guarantee that the most efficient plans will be emulated, if payment rates are reduced. If past history is any judge, it is likely that many of the for-profit plans will cut back on services, providers, or withdraw from unprofitable markets.

If MA Plans Withdraw From The Local Market

Payment cuts in 1997 led to significant withdrawals of what-was-then-termed Medicare+Choice plans. Similarly, the rule changes implemented in 2008 and 2009, led to about 18 percent fewer Medicare Advantage plans being offered in 2010.¹³ Most of the plans that have been dropped had tiny enrollments and simply cluttered the marketplace. Despite these withdrawals, the average Medicare beneficiary still has a bewildering number of Medicare Advantage plans to choose from: 35 in urban areas and 24 in rural ones.¹⁴

Anyone enrolled in Medicare Advantage always has the right to return to traditional Medicare (Part A and Part B).

If their Medicare advantage plan withdraws from their local market, beneficiaries have significant rights to enroll in another plan.

Return to Traditional Medicare. Anyone eligible for Medicare always has the right to return to traditional Medicare Part A (hospital insurance) and Part B (medical insurance) at any time. Just give your MA plan 30 days written notice, and they will notify Medicare. You don't even have to wait for the annual open enrollment period.

If they don't have drug coverage from another source, most enrollees will want to also sign up for a prescription drug plan, often called Part D. Enrollees who had drug coverage with their Medicare Advantage plan can enroll without penalty. If they didn't previously have drug coverage, they may pay a premium penalty.¹⁵

A return to traditional Medicare may mean that you'd want to buy a Medigap policy. These are private plans that fill in the patient cost-sharing associated with traditional Medicare, for example, the hospital deductible (now more than \$1,000 per admission). If your MA plan withdraws from your area of the country and you are 65 or older, you may enroll in Medigap without penalty, but you must apply within 60 days of the end of your MA plan benefits.¹⁶ If your MA plan withdraws, you have the right to purchase this Medigap plan without regard to your medical history or condition.

Switch to another Medicare Advantage plan. Today, almost all seniors are able to choose from at least 10 Medicare Advantage plans, and on average, seniors

have 33 MA plans to choose from.¹⁷ So even if some plans choose to withdraw, most seniors would still have several options.

If you do nothing, and don't select a new plan, you'll automatically revert to traditional Medicare. This could leave you uncovered on prescription drugs unless you affirmatively take steps to purchase a Part D drug plan.

If MA Plans Raise Premiums Or Decrease Benefits

Medicare Advantage plans must provide all benefits covered under Medicare, but have the flexibility to modify the cost-sharing as long as the core benefit package is “actuarially equivalent” (has the same dollar value) to traditional Medicare. If the payments they receive from Medicare exceed what they need to provide this actuarially-equivalent package, the MA plan must offer extra benefits or reduce beneficiary costs. Due to this flexibility, Medicare Advantage plans typically use fixed dollar copayments for Medicare covered services, rather than a coinsurance, and many plans have a limit on enrollees' out-of-pocket spending, unlike traditional Medicare.¹⁸ MA plans often offer extra benefits, but studies show the value of these benefits is often far below their cost to the Medicare program.¹⁹

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Not all MA enrollees pay a premium to participate in MA plans, that is, a premium over and above the Part B premium that all enrollees (traditional or MA) pay to CMS. While not as common among HMO-style plans, almost all MA plans with larger provider networks charge premiums. Today, about 57% of enrollees in MA plans that include drug coverage pay these extra premiums.²⁰

As MA plans respond to changing market conditions and new CMS rules, they often modify their benefits or raise premiums. For example, in 2010, enrollees in MA plans that feature prescription drug coverage saw an average premium increase of 32%.²¹ In another example, between 2008 and 2010, MA plans increased cost-sharing for stays in a Skilled Nursing Facility by 18%.²²

When MA plans raise premiums or reduce benefits, beneficiaries can switch plans during open enrollment. As described below, the rules governing this process vary somewhat from the rules covering plan withdrawals.

Return to Traditional Medicare. Anyone eligible for Medicare always has the right to return to traditional Medicare Part A (hospital insurance) and Part B (medical insurance). Just give your MA plan 30 days written notice, and they will notify Medicare.

The process is slightly different if you want to enroll in supplementary coverage for drugs (Part D) or Medigap coverage. You can join a Medicare Prescription drug plan during the annual open enrollment period (Nov. 15-Dec. 31). If your prior plan didn't include drug coverage, there is a premium penalty.

If you leave your Medicare Advantage plan because of higher premiums or reduced benefits, you are considered to have left “voluntarily.” As such, **you may not be able to enroll in any Medigap plan you want.** Your protections will depend on the state you live in.²³ A majority of states do not guarantee access to Medigap plans, once a senior’s initial enrollment period (usually around age 65) has ended. In states without these protections, Medigap plans may require you to undergo medical underwriting (an examination of your health history and a physical exam). Based on these underwriting results, Medigap insurers may not sell you a policy, or may charge you higher rates.

Switch to another Medicare Advantage plan. During annual enrollment (Nov. 15-Dec. 31), you can switch to another MA plan. You can also switch from January 1- March 31 each year, but can’t join or switch to a plan with prescription drug coverage during this period unless your prior plan also featured drug coverage.

If you do nothing, you will continue to be enrolled in the prior year’s plan.

In Conclusion

Medicare Advantage enrollees confronted with a plan withdrawal, a significant increase in premiums, or a major reduction in plan benefits, have strong rights to return to traditional Medicare or enroll in another MA plan. The greatest weakness in these protections involves their ability to enroll in Medigap (Medicare Supplemental) coverage. If they leave their MA plan “voluntarily,” seniors could be denied Medigap coverage or face higher premiums, depending on the rules for their state.

There also seems to be considerable latitude for MA plans to respond to payment changes by becoming more efficient, thereby realizing the original vision for these plans and improving their value for taxpayers and the Medicare beneficiaries who fund the program through their Part B premiums.

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ENDNOTES

- 1 B. Biles, L. Hersch Nicholas, and S. Guterman, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?*, The Commonwealth Fund, May 19, 2006.
- 2 Medicare Payment Advisory Commission. *Report to Congress: Medicare Payment Policy*, March 2010.
- 3 Brian Biles, Jonah Pozen, and Stuart Guterman. *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 Billion in 2009*, The Commonwealth Fund, May 4, 2009.
- 4 Rick Foster, "Letter to Congressman Stark," Office of the Actuary, Centers for Medicare and Medicaid Services, June 25, 2009.
- 5 Ibid.
- 6 The unappealing alternatives to extend the life of the Medicare Trust Fund are (1) raising taxes on younger workers, many of whom have no health insurance, (2) cutting essential core benefits in traditional Medicare, or (3) paying hospitals and doctors less (which carries the danger of those providers not wanting to provide care to traditional Medicare enrollees).
- 7 Medicare Payment Advisory Commission, "Report to Congress: March 2010 – Fact Sheet," March 2010.
- 8 A 2009 CMS analysis found that twenty-seven percent of total Medicare Advantage plans have fewer than 10 enrollees.
- 9 About 57% of enrollees are in plans that charge a premium, in addition to the Part B premium that beneficiaries pay to CMS. While not as common among HMO-style plans, almost all MA plans with larger networks of providers charge premiums.
- 10 Payments to MA organizations are, in part, based on the projected expenditures organizations submit in their bids for providing Medicare-covered services, as well as actual enrollment and beneficiary health status. See *Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006*, December 8, 2008 letter from GAO to The Honorable Pete Stark. <http://www.gao.gov/new.items/d09132r.pdf>
- 11 United States House Of Representatives, Committee On Energy And Commerce Majority Staff. *Profits, Marketing, And Corporate Expenses In The Medicare Advantage Market*, December 2009, http://energycommerce.house.gov/Press_111/20091209/MedicareAdvantageReport120909.pdf
- 12 Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy," March 2010.
- 13 Gold, Marsha, Phelps, Dawn, Neuman, Tricia & Jacobson, Gretchen. *Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums*. Kaiser Family Foundation, February 2010. <http://www.kff.org/medicare/upload/8007.pdf>.
- 14 Ibid.
- 15 If you want to purchase Part D prescription drug coverage after your initial enrollment period (typically, when you turn 65), and you are coming from a plan that does not have prescription coverage that is as good as Medicare's prescription drug coverage, you will pay a premium penalty. The penalty is at least an extra 1 percent of the national average premium for each month that you delay and are without "creditable" drug coverage. This amount will be added to your Part D premium for as long as you have Medicare prescription drug coverage. See: http://bulletin.aarp.org/yourhealth/medicare/articles/making_a_decision_whether_to_enroll_in_part_d.html
- 16 Beneficiaries age 65 or older have the right to purchase Medigap plans A, B, C, F, K or L, if their Medicare Advantage plan withdraws from the market. Beneficiaries under age 65 do not have the same rights.
- 17 Gold, Marsha, Phelps, Dawn, Neuman, Tricia & Jacobson, Gretchen. *Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums*. Kaiser Family Foundation, February 2010. <http://www.kff.org/medicare/upload/8007.pdf>
- 18 Gold, Marsha, Maria Huston, Gretchen Jacobson and Neuman, Tricia. *Medicare Advantage 2010 Data Spotlight: Benefits and Cost-sharing*. Kaiser Family Foundation, February 2010 <http://www.kff.org/medicare/upload/8047.pdf>

- ¹⁹ Medicare Payment Advisory Commission, “Report to Congress: Medicare Payment Policy,” March 2010.
- ²⁰ Gold, Marsha, Phelps, Dawn, Neuman, Tricia & Jacobson, Gretchen. *Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums*. Kaiser Family Foundation, February 2010. <http://www.kff.org/medicare/upload/8007.pdf>.
- ²¹ Ibid.
- ²² Gold, Marsha, Maria Huston, Gretchen Jacobson and Neuman, Tricia. *Medicare Advantage 2010 Data Spotlight: Benefits and Cost-sharing*. Kaiser Family Foundation, February 2010. <http://www.kff.org/medicare/upload/8047.pdf>
- ²³ Under current law, states can confer additional protections. In Connecticut, for example, any insurance company which sells Medigap plans A through L must sell them to any Medicare beneficiary over the age of 65 at any time, regardless of age, gender, medical condition or previous health insurance claims history. Insurance companies are prohibited from refusing coverage under these plans based upon a person’s medical conditions or medical history.