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Medicare Advantage Plans: Buyer Beware

The abuses we warned you about are happening. The Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce held a hearing in June on the need for greater oversight of Medicare Advantage (MA) organizations and plans. This hearing was triggered by several government watchdog reports that show MA plans delay and deny needed care, exhibit troubling patterns of disenrollment, and cost the federal government and taxpayers more than original Medicare.

In April the HHS Office of Inspector General (OIG) found that MA plans sometimes delayed or denied services even though requests met Medicare coverage rules and would have been delivered under Original Medicare. Sometimes the MA plans claimed not to have sufficient documentation to support approval, yet reviewers found that the medical records already in the case file were sufficient to support the medical necessity of the services. Based on their samples, OIG estimates that tens of thousands of beneficiaries receive an inappropriate denial every year. Some denials are reversed on appeal, but many are not. And, of course, many people simply accept the plan's decision without filing an appeal. In the end, these practices have led to worse health outcomes as needed care is either delayed or not provided at all.

Last year the Government Accountability Office (GAO), a watchdog agency in the legislative branch, released a report showing that people in their last year of life disproportionately disenrolled from Medicare Advantage (MA) into Original Medicare. These end-of-life disenrollments were at ten times the rate of regular disenrollments, suggesting that MA plans push people off their plans when care gets more expensive. Beneficiaries who disenrolled cited barriers to getting needed care and problems accessing their preferred providers as reasons for switching coverage.

In March, the Medicare Payment Advisory Commission (MedPAC) delivered its annual report to Congress that examines Medicare's payment policies, including Medicare Advantage (MA). By MedPAC's estimates, Medicare pays four percent more for beneficiaries who are enrolled in MA than it would if those beneficiaries were covered by traditional Medicare. One reason is "upcoding" or stating that a patient is

sicker than they really are. For example, the OIG flagged billions of dollars of payments to MA plans based on diagnoses that were found only on medical records and that did not lead to any treatment. Researchers have found similar results, showing that hundreds of billions of dollars may be at stake due to upcoding.

These watchdog reports generally end by urging CMS or Congress to increase their oversight of MA plans in order to root out the abuses. They also call on the MA organizations themselves to implement better policies and procedures. No one, it seems, is standing up for the ordinary Medicare beneficiary who just wants access to good care at a reasonable cost. It is falling to financial advisors, who have no skin in the game, to advocate for their clients when it comes to health insurance.

We continue to recommend that advisors try to steer clients away from Medicare Advantage plans, if possible. You will be bucking the trend, as MA enrollment is increasing, not decreasing. Healthy people coming off workplace plans are drawn in by MA plans' via slick marketing and are enticed by low premiums and additional benefits (vision, hearing, gym memberships). Younger, healthier Medicare enrollees don't plan to get sick, so why should they pay higher premiums for more comprehensive coverage or worry about claim denials? But they should know that if they do get sick their costs could be higher than under Original Medicare with a Medigap policy and drug plan.

Make sure clients understand the potential difficulties of getting a Medigap policy if they don't sign up when they first enroll in Medicare. Clients who start out with a MA plan and later decide to switch to a Medigap policy may find themselves unable to get one due to the insurers' underwriting requirements. Make sure clients know that unless they live in a state that prohibits Medigap insurers from denying their application, they could forever be relegated to the MA marketplace. No one is telling clients this. It's up to us to do so.

Tell them about the one-year MA trial right. If clients insist upon going into an MA plan when they first enroll in Medicare, make sure they know they have an out that first year. Under the MA trial right, they can drop the MA plan and buy any Medigap policy sold in the state. Or, if they started out with a Medigap policy and dropped it to go into a MA plan, they have one year to change their mind and get their same Medigap policy back. If that same policy is no longer offered, they can get any policy sold in the state.

Know what could be involved in switching to Medigap in your state. Clients who miss their one-year trial right may still be able to get a Medigap policy. Here it would pay to find a good insurance agent who specializes in Medicare policies and understands which health conditions are more troublesome and which insurers tend to have more lenient underwriting standards.

We will concede that there are some good MA plans out there, primarily those in large urban areas where there is lots of competition. And much of the variability in experience has to do with a client's own health status. Clients who are and expect to stay healthy won't need to worry so much about high copayments, claim denials, or the inability to receive specialty care due to narrowing networks. The lower premiums may compensate for these potential problems. But like we said: Buyer beware.

Further reading

- Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage