California Senior Medicare Patrol
and
Center for Medicare Advocacy

Webinar Series
Senior Medicare Patrol (SMP)

CMA Webinar:
Medicare Advantage Overview & Concerns

Marissa Whitehouse
SMP Program Manager
Administration for Community Living

Catherina Isidro
Executive Director
California Health Advocates

November 17, 2022
What is the Senior Medicare Patrol (SMP)?

Mission
To empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

- Grant-based program administered by ACL since 1997
- 54 State Projects: One in every state, DC, PR, GU, and USVI
  - 5,720 Team Members nationally
- SMP’s goals:
  - To prevent Medicare fraud before it happens via public outreach and one-on-one assistance and
  - To report suspected issues as quickly as possible to the proper investigators
- SMP is known as a trusted OIG & CMS partner and provides a direct link from Medicare beneficiaries to fraud investigators
- SMP Resource Center: [www.SMPResource.org](http://www.SMPResource.org)
SMP’s Role in Health Care Fraud Reporting

**PREVENT:** SMPs provide focused outreach and messaging designed to protect Medicare beneficiaries from Medicare fraud.

**DETECT:** As local trusted connections in the community the SMPs are often the first to hear of new issues as they begin to emerge.

**REPORT:** SMPs provide in-depth one-on-one assistance to Medicare beneficiaries and other complainants.
SMP National Resource Center

- Promotes national visibility for the SMP program and helps the general public locate their state SMP project
- Provides a national website, social media, toll-free number, and info@ email
- Promotes SMP networking and the sharing of best practices
- Provides education and information about health care fraud, error, and abuse
- Develops new products and tools for use by the national SMP network
- Provides training and technical assistance to SMPs
Providing quality Medicare and related healthcare coverage information, education and policy advocacy.

Advocacy & Policy
Improving rights and protections for Medicare beneficiaries and their families

Education
Website, fact sheets and educational workshops

Senior Medicare Patrol
Fraud prevention education

California Health Advocates
www.cahealthadvocates.org
Click on the Fraud & Abuse tab:
SPANISH IN THE BACK

TAGALOG IN THE BACK

HOSPICE FRAUD ALERT!

Have you suddenly lost access to your doctor?

Are your specialists refusing to see you?

Can’t get your medications at the pharmacy?

BEWARE!

You may have been tricked into signing up for a program that is medically unnecessary for you.

Hospice is a benefit covered by Medicare and it is meant for Medicare beneficiaries with a terminal illness.

Some hospice agencies may approach you outside of inpatient hospital or may show up to your home unannounced and recruit non-terminally ill Medicare beneficiaries by offering you free items or services and making themselves a “program that helps everyone.”

If you or someone you know signed up for these services but now fears accessing medical care, please contact the Senior Medicare Patrol immediately at:

855-613-7080

carehealthadvocates.org

Cardiac Genetic Testing

Scammers are offering Medicare beneficiaries cardiac genetic testing to obtain their Medicare information for fraudulent billing purposes or possibly medical identity theft.

- Only give your Medicare number to trusted providers.
- Do not accept a genetic test kit from cold call or robo-call.
- Cardiac Marker - Test

REPORT THIS SCAM TO THE SMP AT 1-855-613-7080

For additional information on healthcare fraud, visit:

cahealthadvocates.org

SPANISH IN THE BACK
SMP Materials

Medicare Fraud Alert
Beware of Scams

Do not respond to offers for free medical equipment or services.

Check your medical statements routinely for services not provided.

Call us for a FREE fraud prevention presentation or for guidance if you suspect you may be the victim of fraud.

Share your Medicare number only with your trusted providers.

Report Medicare Fraud to California Senior Medicare Patrol.

855-613-7080

Contact Kristina Teotico at:
kteotico@cahealthadvocates.org
Join Us for Our Upcoming Webinars Partnered with Center for Medicare Advocacy!

- January 19: Help Available for Lower Income Beneficiaries
- February 23: Medicare Home Health Coverage and Updates
- March 23: Medicare Skilled Nursing Facility Coverage & Updates
- May 25: Voices of Medicare - Pressing Beneficiary Issues
SMP Program Questions:
Marissa Whitehouse
Marissa.whitehouse@acl.hhs.gov

State SMP Program Locator:
SMP National Resource Center
https://www.smpresource.org/Default.aspx

CA Medicare Fraud/Errors/Abuse:
California SMP
855-613-7080
Medicare Advantage Overview & Concerns

California Health Advocates Webinar
November 17, 2022

David Lipschutz, Center for Medicare Advocacy
Judy Stein, Center for Medicare Advocacy
The Center for Medicare Advocacy is a national, non-profit law organization founded in 1986 that works to advance access to comprehensive Medicare and quality health care. Based in Washington, DC and CT, with additional attorneys in CA and MA.

- Staffed by attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects
Agenda

Overview
  - Landscape of Medicare Advantage (MA) in 2023
  - Growing Imbalance with Traditional Medicare

Informed Decision Making
  - Access to Information
  - MA Marketing and Steering

Access to Care in MA Plans
  - Prior Authorization and Denials
  - Network Adequacy
  - Enrollee Costs, Extra Benefits

Future of Medicare
OVERVIEW
Overview Of Medicare

Four “Parts” of Medicare:

• **Part A** – Hospital Insurance
  Traditional or Original Medicare (Administered by Centers for Medicare and Medicaid Services - CMS)

• **Part B** – Medical Insurance
  • Supplemental Coverages (e.g. Medigap Plans, Medicare Savings Programs, Retirement, VA/Military Plans)

• **Part C** – Medicare Advantage program – Private Insurance Companies
  • MA – Medicare Advantage Plan without Part D drug coverage
  • MA-PDs – Medicare Advantage with Part D drug coverage

• **Part D** – Prescription Drug Program – Private Insurance Companies
  • PDP – Stand-Alone Prescription Drug Plans
Overview: Medicare Advantage in 2022

Kaiser Family Foundation: In 2022, 48% of eligible Medicare population is in MA; “Enrollment is projected to cross the 50 percent threshold as soon as next year, making Medicare Advantage the predominant way that Medicare beneficiaries with Parts A and B get their coverage and care.”

- In 25 states, at least half of all Medicare beneficiaries are enrolled in MA
- Nearly 1 in 5 (18%) MA enrollees are in group plans through former employers, unions
- Enrollment is concentrated: UnitedHealthcare and Humana account for nearly half of all MA enrollees nationwide (46% in 2022)
Medicare Advantage in 2023

- Average beneficiary in 2023 will have access to 43 MA plans (35 of which include drug coverage (MA-PDs)
  - HMOs account for about 6 in 10 plans (58%), local PPOs approx. 40%
  - Metro areas – av. of 46 plans in 2023, 29 plans in non-metro areas
  - In 27 counties (predominantly in OH and PA) 75+ plans offered (high of 87 plans – Summit, OH)

Growing Imbalance Between MA and Traditional Medicare

- Policymakers have generally supported policies that further this imbalance, including re:
  - Payment
    - Significant Overpayments to MA plans – MedPAC – “excess Medicare spending of almost $15 billion in 2022 alone”
    - Some estimates much higher
  - Coverage of Items/Services
    - Supplemental benefits, including those addressing SDOH
  - Ease of Enrollment
    - Compare, e.g., to Medigaps
    - MA plan marketing and Medicare program MA steering
Medicare Advantage Payment

- There is consistent and growing evidence that MA plans are paid more on average than trad, Medicare spends on a given beneficiary, and such spending is growing per person, with significant implications for Medicare programmatic spending (see, e.g., *CMA Alert* (May 5, 2022))
- See, e.g., Urban Institute “*Understanding Medicare Advantage Payment – How the Program Allows and Obscures Overspending*” (Sept. 2022)
  - Excerpt from Intro: “MA is also profitable for insurers and has widespread bipartisan political support. MA plans have reduced health care utilization, but **although MA was also supposed to generate Medicare program savings, it never has**. Policy groups such as the Medicare Payment Advisory Commission (MedPAC) have long understood and explained that MA plans are overpaid relative to TM when viewed on comparable terms” [emphasis added].
  - As a result of the current plan payment structure (including bids, benchmarks and bonus payments) in 2022, average MA enrollee has access to nearly $2,000 in extra benefits not available to trad. Medicare enrollees
INFORMED DECISION-MAKING
Medicare Advantage
Enrollment Periods

- **Initial Coverage Election Period (ICEP)** - can enroll in an MA plan during period of 3 months before an individual is entitled to both Parts A and B, effective 1st day of month of entitlement to both A and B

- **Annual Open Enrollment Period (AEP)** (Fall Open Enrollment) October 15-December 7. May change plans or enroll into Part D. Changes take effect on January 1st of the next calendar year

- **Medicare Advantage Open Enrollment Period (MAOEP)** January 1-March 31 (only if you have an MA plan). Changes take effect on the first of the next month

- **Special Enrollment Periods**
Choice Between MA & Traditional Medicare (and Between MA Plans)

- See CMA “Choosing Between Traditional Medicare and Medicare Advantage” at: https://medicareadvocacy.org/choosing-between-traditional-medicare-and-a-medicare-advantage-plan/

Medicare Advantages Tradeoffs for Beneficiaries

Potential Advantages

• One stop shopping – no need for Medigap or separate Part D plan
• Lower premiums than Medigap; most pay no premium other than Part B
• Plans typically offer additional benefits (like dental)
• Plans have an out-of-pocket limit for benefits covered under Parts A and B
• Potential for better coordinated care

Potential Disadvantages

• Limited provider network
• Potential for higher out-of-pocket costs for certain services
• More utilization review than traditional Medicare
• No choice of separate drug plan to reduce drug costs
• Limited ability to switch back to traditional Medicare with Medigap
Many Factors to Consider When Choosing Among the Many Medicare Part D and Advantage Plans

**How Part D Plans Vary:**
- Premiums
- Deductibles
- Covered drugs
- Number of tiers
- Cost-sharing or coinsurance
- Tier placement (e.g., preferred or not)
- Preferred pharmacies
- Savings/cost of mail order
- Quality ratings

**How Medicare Advantage Plans vary:**
- Premiums, in addition to Part B premiums
- Cost-sharing for inpatient care and other Medicare-covered benefits
- Provider networks
- Extra benefits – scope of coverage
- Quality ratings
- Prior Authorization and other cost management restrictions
- All the same ways Part D plans vary
Most Medicare Advantage Plans Offer Benefits Not Covered Under Traditional Medicare in 2022

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exams and/or eyeglasses</td>
<td>98%</td>
</tr>
<tr>
<td>Fitness</td>
<td>97%</td>
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<tr>
<td>Telehealth</td>
<td>95%</td>
</tr>
<tr>
<td>Hearing exams and/or aids</td>
<td>95%</td>
</tr>
<tr>
<td>Dental</td>
<td>94%</td>
</tr>
<tr>
<td>Remote Access Technologies</td>
<td>74%</td>
</tr>
<tr>
<td>Meal Benefit</td>
<td>67%</td>
</tr>
<tr>
<td>Transportation</td>
<td>38%</td>
</tr>
<tr>
<td>In-Home Support Services</td>
<td>10%</td>
</tr>
<tr>
<td>Bathroom Safety Devices</td>
<td>8%</td>
</tr>
</tbody>
</table>

Choice of Coverage is Unequal

- Unequal rights to choose coverage options
  - Can get in and out of an MA plan on an annual basis
    - Plus MA-OEP options, if begin year with MA – no similar opportunities for those with PDPs
  - Medigap rights limited in most states
    - Limited periods when plans must sell to you
      - No federal right for individuals under 65
    - Many people will not be able to later purchase a Medigap policy if they miss their initial enrollment
Some People Don’t Have a Choice

- Nearly 1 in 5 (18%) MA enrollees are in group plans through former employers, unions
  - Many don’t have a choice of other options if they wish to retain retiree coverage
- Others??
KFF (Nov. 2022): “The marketplace of Medicare private plans operates on the premise that people with Medicare will compare plans to select the best source of coverage, given their individual needs and circumstances. [...] With a relatively small share of beneficiaries actively comparing their Medicare coverage options during the open enrollment period, it is no surprise that an even smaller share of Medicare Advantage and Part D prescription drug plan enrollees switch plans from one year to the next.”

Every year MA plans can change premium, cost-sharing (including out-of-pocket limit), coverage and coverage rules (including prior auth requirements), type and scope of extra benefits covered, provider networks, drug formularies, etc. (or even whether to continue offering a plan)

• Entire system of choice relies on active, annual engagement of savvy, informed consumers maximizing coverage options
Comparing Plans

Most people do not compare MA and Part D plans

• Kaiser Family Foundation (KFF) report “A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period” (Nov. 1, 2022) found:
  • Just 3 in 10 (29%) Medicare beneficiaries compared their current Medicare plan with other Medicare plans offered in their area.
  • About half (54%) of all Medicare Advantage enrollees reviewed their current plan’s coverage to check for potential changes in their plan’s premiums or other out-of-pocket costs, while the remaining half (46%) did not. The same share (54%) said they reviewed their current plan for potential changes in the kinds of treatments, drugs, and services that would be covered in the following year.
  • Medicare’s official information resources are generally not widely used by Medicare beneficiaries
  • Certain sub-groups less likely to make comparisons/review coverage, including lower income, certain race/ethnicity groups, age 85+, dually-eligible for Medicare and Medicaid, cognitively impaired
Plan Quality Ratings

 Means of comparing plans – Quality Star Ratings
 • In 2022, 9 out of 10 [89.7%] MA members are enrolled in plans that earned 4 or 5 stars
   • Changes in 2023 ratings – approx. 72% of people currently in MA-PDs with 4 or more stars (see CMS Press Release, 10/6/22)
 • MedPAC – (2022) “[t]he current state of quality reporting is such that the Commission can no longer provide an accurate description of the quality of care in MA.”
 • JAMA article (Oct. 2022) “The current system for rating the quality of MA plans does not allow consumers to make meaningful comparisons.”
Where Do People Get Information about Medicare?

- KFF (Nov. 2022): “Medicare’s Information Resources—Especially the 1-800 Medicare Toll-Free Number—Are Not Widely Used by Beneficiaries”
  - 7 in 10 reported that they either never called 1-800-MEDICARE or were aware it existed
  - 51% have never read, didn’t receive (or know if they had received) the Medicare & You Handbook
  - 56% reported they never visited medicare.gov or did not have access to internet or had no one to access it for them

- Commonwealth Fund “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (Oct. 2022)
  - About 1 in 3 Medicare beneficiaries – regardless of coverage– used insurance brokers or agents to choose a plan, compared with approximately 5% who used a State Health Insurance Assistance Program (SHIP).
Marketing Misconduct

- CMS reported that beneficiary complaints about MA marketing misconduct more than doubled between 2020 and 2021
- Senate Finance Committee report issued a report titled “Deceptive Marketing Practices Flourish in Medicare Advantage” (Nov. 3, 2022) finding “evidence that beneficiaries are being inundated with aggressive marketing tactics as well as false and misleading information”
  - Report “exposes numerous tactics used by insurance companies, brokers, and third-party marketers to push seniors to sign up for their plans, including deceptive mail advertisements, misleading claims about increasing Social Security benefits, aggressive in-person marketing tactics, and enrolling beneficiaries, particularly those dually eligible for Medicare and Medicaid, in a new plan without their consent.”
  - Report found a “consistent national picture” of fraudulent and misleading marketing practices that are “widespread, not isolated events.”
Marketing Misconduct

- What drives such misconduct?
  - Is it, perhaps, significant financial incentives for plans and those who sell them?
  - See, e.g., *CMA Alert* “*Senate Report Highlights Widespread Medicare Advantage Marketing Misconduct – But the Driving Forces of Misconduct Are Broader*” (Nov. 10, 2022)

- MA Commissions
  - See, e.g., Commonwealth Fund (2021) - max. national commission for initial enrollment in MA plans in 2022 is $573 per beneficiary in most parts of the country (in CA = $715) vs. max. national commission for first-time Part D plan enrollment of $87
  - See, e.g. *MedPage Today* (Oct. 14, 2022) commissions for sales of MA plans can be twice as much compared to a Medigap plan
CMS Oversight

- In an Oct. 2021 memo to plan sponsors, CMS flagged concern “with national advertisements promoting MA plan benefits and cost savings, which are only available in limited service areas or for limited groups of enrollees, as well as using words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government.”

- In an Oct. 2022 memo, CMS informed plan sponsors about its monitoring activities, shared “plan best practices for the current AEP”, and outlined changes to its “file and use” policy with respect to TV advertisements starting January 2023.

- In an accompanying FAQ, CMS noted that its review of recordings of agent and broker calls found that “The agents failed to provide the beneficiary with the necessary information or provided inaccurate information to make an informed choice for more than 80 percent of the calls reviewed.”
MA Steering

- In recent years, Medicare program itself promoted MA over trad. Medicare
- CMS Steering since 2017 ACEP
  - Outreach, education materials (including *Medicare & You* revised, resulting in, among other things, omitting or limiting reference to traditional Medicare, and encouraging MA enrollment (over trad. Medicare)
  - Rather than presenting differences between traditional Medicare and MA in a neutral, unbiased manner, CMS has been overplaying the pluses of MA and downplaying any minuses in a manner that is highly misleading, at best
  - Targeted email campaigns promoting MA enrollment
MA Steering

- 2022 and 2023 versions have improved (see, e.g., CMA reports in 2021 and 2022)
  - Example: 2023 version, more accurate descriptions of:
    - Prior Authorization: “In many cases, you may need to get approval from your plan before it covers certain drugs or services”
    - Out-of-pocket costs: “Out-of-pocket costs vary—plans may have lower or higher out-of-pocket costs for certain services.”
- While some CMS materials have improved, still work to do, including www.medicare.gov website and email campaign
  - See, e.g., CMA Special Report | “Recent Articles and Reports Shed Light on Medicare Advantage Issues” (Oct. 31, 2022)
Practical Tip

Special Enrollment Periods (SEPs)

- See Special Enrollment Periods (SEPs) at 42 C.F.R. §§ 422.62(b); See Medicare Managed Care Manual, Ch. 2, §30.4.4.21 at https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

- Including 422.62(b)(3) The individual demonstrates to CMS that –
  - (i) The organization offering the plan substantially violated a material provision of its contract under this part in relation to the individual, including, but not limited to the following: (A) Failure to provide the beneficiary on a timely basis medically necessary services for which benefits are available under the plan. (B) Failure to provide medical services in accordance with applicable quality standards; or
  - (ii) The organization (or its agent, representative, or plan provider) materially misrepresented the plan's provisions in communications as outlined in subpart V of this part. [emphasis added]
Is MA “Better” for Beneficiaries?

- Insurance industry often paints MA as better for beneficiaries than trad. Medicare
  - Example: “More than 28 million seniors and people with disabilities choose Medicare Advantage (MA) because it delivers better services, better access to care, and better value.” AHIP (industry organization)
  - Example: MA is “delivering better health outcomes, through better quality care at a better cost for Medicare beneficiaries.” Better Medicare Alliance (industry organization)

- But is that true …?

- KFF report (9/16/22) “Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature” - examined 62 studies published since 2016 that compare Medicare Advantage and traditional Medicare based on measures of beneficiary experience, affordability, service utilization, and quality.
Excerpt from Executive Summary:

“We found few differences between [MA] and traditional Medicare that are supported by strong evidence or have been replicated across multiple studies. Both [MA] and traditional Medicare beneficiaries reported similar rates of satisfaction with their care and overall measures of care coordination. [MA] outperformed traditional Medicare on some measures, such as use of preventive services, having a usual source of care, and lower hospital readmission rates. However, traditional Medicare outperformed [MA] on other measures, such as receiving care in the highest-rated hospitals for cancer care or in the highest-quality skilled nursing facilities and home health agencies. Additionally, a somewhat smaller share of traditional Medicare beneficiaries than [MA] enrollees experienced a cost-related problem, mainly due to lower rates of cost-related problems among traditional Medicare beneficiaries with supplemental coverage. Several studies found lower use of post-acute care among [MA] enrollees but were inconclusive as to whether that was associated with better or worse outcomes.”
KFF Report – Areas Where MA Performs Worse

- **Switching from MA to TM**: “rates of switching from Medicare Advantage to traditional Medicare were relatively higher among beneficiaries who are dually eligible for Medicare and Medicaid, beneficiaries of color, beneficiaries in rural areas, and following the onset of a functional impairment. Switching rates may be a proxy for dissatisfaction with current coverage arrangements.”

- **Post-Acute Care**: “lower rates of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and home health use among Medicare Advantage enrollees, and shorter lengths of stay in SNFs and IRFs for Medicare Advantage enrollees than traditional Medicare beneficiaries”

- **Quality of Providers**: “Medicare Advantage enrollees were less likely than traditional Medicare beneficiaries to receive care in the highest-or lowest-rated hospitals overall or in the highest-rated hospitals for cancer care, skilled nursing facilities (SNFs), and home health agencies.”

- **Affordability**: “a somewhat larger share of Medicare Advantage enrollees than traditional Medicare beneficiaries experienced a cost-related problem, mainly due to lower rates of cost-related problems among traditional Medicare beneficiaries with supplemental coverage […] Medicare Advantage enrollees who are Black, under age 65 with disabilities, or in fair or poor health were more likely to report cost-related problems than their traditional Medicare counterparts.”
Medicare Advantage and Access to Care

- Widespread use of Prior Authorization (PA) - (KFF – 99% of MA enrollees in plans that use PA for some services - “most often required for relatively expensive services, such as Part B drugs (99%), skilled nursing facility stays (98%), and inpatient hospital stays (acute: 98%; psychiatric: 94%), and is rarely required for preventive services (6%)”)


- HHS Office of Inspector General (OIG)
  - 2018 Report – plans overturn 75% of prior auth and payment denials, but benes and providers appeal only 1% of denials
  - 2022 Report – among sample of 2019 denials, found 13% of prior auth denials met Medicare coverage rules, 18% of payment denials met rules
Medicare Advantage (MA) Denials

• Is it actually worse than OIG found?

• Apparent increased use of Artificial Intelligence (AI) driven coverage decision-making software (e.g., naviHealth, myNexus, CareCentrix)
  • Individualized assessments, as required?
  • In our experience, this leads to frequent and multiple denials (particularly in SNF setting)
  • See e.g., MA SNF Survey (CT) CMA conducted in April (see 8/18/22 CMA Alert: https://medicareadvocacy.org/report-nursing-home-ma-issues-survey/)
MA Denials

- We have heard an increase in complaints from MA enrollees in SNFs – frequently win expedited appeals, plan (or contractor) often respond by issuing a new denial notice within several days (often leading to multiple denials)
  - See *Kaiser Health News* article (10/4/22)

- One must appeal to contest individual denials, but no formal way in appeals process to prevent plan from issuing multiple denials; in addition to filing an appeal, one can file grievance with plan
  - Plan must respond in writing and complete certain reporting requirements to CMS (please send us copies!!)
Provider Networks

- **HMOs** usually have no out-of-network coverage (other than emergency, urgent services)
- **PPOs** usually have out-of-network coverage at a higher cost to the beneficiary
- Network providers may choose to join or leave a network at any time; plans can also terminate providers at any time, whereas most enrollees are locked in for a year
  - Limited SEP for network terminations
- Plan networks may not always have adequate specialists or other providers to serve patient needs.
  - Online provider/hospital/supplier/network directories are not always accurate or updated
Network Adequacy Rules

- CMS weakened MA network adequacy rules in June 2020 Final Rule
  - Reduced the percentage of beneficiaries that must reside within the maximum time and distance standards in non-urban counties from 90 percent to 85 percent
  - Further 10% credit if plan provides certain services via telehealth
  - Removed dialysis facilities from time and distance standards

- CMS imposed new requirement re: meeting minimum requirements before a plan can be offered in May 2022 Final Rule
  - Plan sponsor applicants must demonstrate (rather than just attest) that they meet network adequacy requirements for a pending service area at application
42 CFR §422.112 – Access to Services

(a) An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

- (1) Provider network –
  - (i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. […]

- (3) Specialty care. Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs. [Emphasis added]
Special Enrollment Periods (SEPs)

- See Special Enrollment Periods (SEPs) at 42 C.F.R. §§ 422.62(b); See Medicare Managed Care Manual (MMCM), Ch. 2, §30.4 at https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

  - SEP at 42 CFR §422.62(b)(23) Individuals affected by a significant change in plan provider network are eligible for a SEP that permits disenrollment from the MA plan that has changed its network to another MA plan or to original Medicare.

  - SEP for Other Exceptional Circumstances - See MMCM Ch. 2, §30.4.4.21 [language in next slide]
SEP for Exceptional Circumstances

- “Circumstances beyond the beneficiary’s control that prevented him or her from submitting a timely request to enroll or disenroll from a plan during a valid election period […] including] a serious medical emergency of the beneficiary or his or her authorized representative during an entire election period, a change in hospice status, or mailed enrollment or disenrollment requests returned as undeliverable on or after the last day of an enrollment period

- “Situations in which a beneficiary provides a verbal or written allegation that his or her enrollment in a MA or Part D plan was based upon misleading or incorrect information provided by a plan representative or [SHIP] counselor, including situations where a beneficiary states that he or she was enrolled into a plan without his or her knowledge or consent, and requests cancellation of the enrollment or disenrollment from the plan.”

- “A SEP may be warranted to ensure beneficiary access to services and where without the approval of an enrollment exception, there could be adverse health consequences for the beneficiary. This is inclusive of, but not limited to, maintaining continuity of care for a chronic condition and preventing an interruption in treatment.”
MA ENROLLEE COSTS & PLAN BENEFITS
P&iuml;remiums

- Many MA plans do not charge premiums (in large part due to the structure of the bidding process)
  - KFF: in 2022, 69% of enrollees in MA-PD plans pay no premium other than Part B
  - 17% of MA plans will offer some reduction in the Part B premium in 2023
    - [* Subject of many misleading ads]
MA Enrollee Costs

- Unlike traditional Medicare, there is required out-of-pocket cap (MOOP) in MA plans, however despite MOOP, people in MA plans can pay more for care than those in trad. Medicare
  - A recent KFF report found that about half of all MA enrollees would incur higher costs than beneficiaries in traditional Medicare for a 7-day hospital stay (See report, Aug. 2022)
  - As the MOOP grows higher, the cost-benefit analysis of monthly premiums for a Medigap and PDP for someone in TM looks more favorable
- Among the conclusions of KFF reports analyzing beneficiary costs:
  - Rates of cost-related problems are higher among MA enrollees than those in traditional Medicare with supplemental coverage and “[a]mong Black beneficiaries specifically, a larger share of those in Medicare Advantage reported cost-related problems than those in traditional Medicare (32% vs. 24%).” (See report, June 2021)
# 2023 MOOP Limits by Plan Type

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Lower MOOP Limit (*50%)</th>
<th>Intermediate MOOP Limit (*40%)</th>
<th>Mandatory MOOP Limit (*30%)</th>
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</thead>
<tbody>
<tr>
<td>HMO</td>
<td>$0 - $3,650</td>
<td>$3,651 to $6,000</td>
<td>$6,001 - $8,300</td>
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<tr>
<td>HMO POS</td>
<td>$0 - $3,650 in-network</td>
<td>$3,651 to $6,000</td>
<td>$6,001 - $8,300 in-network</td>
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<td>Local PPO</td>
<td>$0 - $3,650 in-network and $0 - $5,450 Combined</td>
<td>$3,651 to $6,000 in-network and $3,651 - $8,950 Combined</td>
<td>$6,001 - $8,300 in-network and $6,001 - $12,450 Combined</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>$0 - $3,650 in-network and $0 - $5,450 Combined</td>
<td>$3,651 to $6,000 in-network and $3,651 - $8,950 Combined</td>
<td>$6,001 - $8,300 in-network and $6,001 - $12,450 Combined</td>
</tr>
<tr>
<td>PFFS (full network)</td>
<td>$0 - $3,650</td>
<td>$3,651 to $6,000</td>
<td>$6,001 - $8,300</td>
</tr>
<tr>
<td>PFFS (partial network)</td>
<td>$0 - $3,650</td>
<td>$3,651 to $6,000</td>
<td>$6,001 - $8,300</td>
</tr>
<tr>
<td>PFFS (non-network)</td>
<td>$0 - $3,650</td>
<td>$3,651 to $6,000</td>
<td>$6,001 - $8,300</td>
</tr>
</tbody>
</table>

(*) = limit on cost-sharing for certain services (phased in by 2026)
Benefits

- MA Plans must offer benefits that are at least equal to traditional Medicare and cover everything traditional Medicare covers
- MA Plans can waive certain restrictions on coverage (e.g. 95% of MA Plans don’t require 3-day prior hospital stay for SNF coverage)
- MA plans can provide extra benefits not available in trad. Medicare using rebate dollars (including bonus payments)
How Broad are the Benefits?

- KFF (Nov. 2022): “In 2023, 97% or more individual plans offer some vision, fitness, telehealth, hearing or dental benefits. Though these benefits are widely available, the scope of coverage for these services varies. For example, a dental benefit may include cleanings and preventive care or more comprehensive coverage, and often is subject to an annual dollar cap on the amount covered by the plan. [...] Plans are not required to report data about utilization of these benefits or associated costs, so it is not clear the extent to which supplemental benefits are used by enrollees.” [emphasis added]
Available to Everyone?

• In recent years, changes in law and policy have expanded range of supplemental benefits plans can offer, including not primarily health related
• Not all benefits are available to everyone in the plan, and eligibility cannot be determined until someone is actually enrolled in plan
  • Special Supplemental Benefits for the Chronically Ill (SSBCI))
MA and Ancillary Products

- Some agents/brokers selling MA plans are cross-selling “ancillary products” to “fill in the gaps” of MA plans, including hospital indemnity plans (see upcoming CMA Alert)
- Many of the same people selling Medicare Advantage products both highlight and rely upon MA products’ shortcomings in order to promote the sale of ancillary products
Traditional Medicare & MA
Case Study

A Tale of Two Siblings
FUTURE of MEDICARE?
FUTURE?

- **NEJM** article “Medicare Advantage Checkup” (2018):
  - “[w]ithout much fanfare, Medicare has evolved into a program that provides benefits that are more generous to beneficiaries in [MA] plans than to their counterparts in traditional Medicare.” To this point, the authors highlight the “equity issue that arises from providing stronger financial protections, with an out-of-pocket limit, for beneficiaries in [MA] than in traditional Medicare.”
  - Assuming MA enrollment continues to grow, “the Medicare of tomorrow could look much different than it does today—more like a marketplace of private plans, with a backup public plan, and less like a national insurance program.”
MA Overpayments

- *New York Times* article ‘The Cash Monster Was Insatiable’: How Insurers Exploited Medicare for Billions’ (Oct. 8, 2022) by Reed Abelson and Margot Sanger-Katz which focused on “how major health insurers exploited the [Medicare] program to inflate their profits by billions of dollars.”
  - The article notes that even conservative estimates of the scope of such overpayment ($12 billion in 2020 alone, according to MedPAC), would be enough to “cover hearing and vision care for every American over 65.”
  - Noting that there are trade-offs in enrolling in MA rather than trad. Medicare, the article states that MA plans “often have lower premiums or perks like dental benefits — extras that draw beneficiaries to the programs. The more the plans are overpaid by Medicare, the more generous to customers they can afford to be.” This phenomenon, of course, draws more people to MA, accelerating the privatization of the Medicare program.
MA Overpayments

- **Urban Institute** (Sept. 2022): “Any policy reform must initially focus on the massive overpayments to MA, which […] result from markedly inflated benchmarks against which MA plans bid, extra funding from quality bonuses from a flawed star-rating program, and, most importantly, problems with the risk-adjustment payments for Medicare beneficiaries enrolled in MA plans. Together these factors provide about $2,000 in extra funding per beneficiary per year for MA plans to use to entice beneficiaries to enroll.”

- **MedPAC** (March 2022): “as MA enrollment continues to grow, it will further worsen Medicare’s fiscal sustainability. It is imperative that the Congress and the Secretary make policy improvements.”

- Q: what happens to trad. Medicare as MA continues to grow?
Additional MA Oversight?

- With roughly half of all Medicare beneficiaries enrolled in MA plans, has HHS/CMS responded accordingly with respect to oversight and enforcement?
- CMS recently issued a Request for Information (RFI) re: MA (comments were due 8/31/22)
  - CMA comments: [https://medicareadvocacy.org/center-for-medicare-advocacy-submits-comments-re-medicare-advantage/](https://medicareadvocacy.org/center-for-medicare-advocacy-submits-comments-re-medicare-advantage/)
  - Look for …
    - Prior authorization proposed rule in coming weeks
    - Proposed rule of CMS audits of MA plans (RADV audits) by 2/1/2023
    - Proposed 2024 Part C & D rule in early 2023
Conclusion

▪ What do we want Medicare program to look like in the future?

▪ CMA supports parity – payment, coverage, access
  • See, e.g., H.R. 3, passed by the House in December 2019, would reinvest rx savings into expanding trad. Medicare benefits, including adding oral, vision, and dental coverage for all beneficiaries, expanding rights to purchase Medigap coverage, and expanding eligibility for low-income assistance

▪ See CMA Medicare Platform
Questions & Discussion
For further information, to receive the Center’s free weekly electronic newsletter, *CMA Alert*, update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org
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