



Medicare Rights Center

**Too Good to Be True:
The Fine Print in Medicare
Private Health Plan Benefits**

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Introduction

Nearly 8.3 million of the 43 million Americans with Medicare receive their medical care through private insurance companies, also called Medicare Advantage (MA) plans. The government pays the private insurance companies between 12 and 19 percent more than it would cost Medicare to serve the same people, according to the Medicare Payment Advisory Commission (MedPAC), a nonpartisan, independent federal body that advises the U.S. Congress on issues affecting the Medicare program. The non-partisan Congressional Budget Office estimates that the government's cost for these extra payments will amount to \$65 billion over the next five years.

Are private plans worth it?

The Bush administration and its supporters in Congress claim the extra money is a good investment because private insurers offer more generous benefits than Original Medicare. Their view closely echoes the insurance industry's assertion, in the words of its trade group President Karen Ignagni, that private plans "demonstrate their value to Medicare beneficiaries by providing better benefits at lower out-of-pocket costs."¹

Yet at a hearing held in March by the House Ways and Means health subcommittee, Acting Medicare Administrator Leslie Norwalk said that the agency has no data on what services people in private plans actually receive—only what the plans promise. Representative Pete Stark, the California Democrat who heads the subcommittee, reminded Ms. Norwalk that in order for private plan members to "enjoy" the benefits she praised, people have to be able to use them.

The experience of the Medicare Rights Center (MRC) helping people with Medicare get the health care they need shows that private health plans often fail to deliver what they promise. Plan members encounter an obstacle course when trying to get care and coverage, and they may pay more out of pocket costs than what they would have in Original Medicare.

This report, based on the thousands of calls for assistance received by MRC's counselors and caseworkers, provides a unique view into the human consequences of how private health plans operate.

The number of people who are denied needed care or coverage is unknown; the number who reaches out to MRC is but a fraction of them. Most people do not appeal coverage denials. They do not know how to navigate the private insurance companies' systems, what they are entitled to or who to go to for help. They may not hear or see very well, or they may just be reluctant or physically or mentally unable to fight an insurance company. Many will give up and pay extra for something they should not have to pay for or, worse, go without needed medical care.

How Medicare Private Health Plans Work

People with Medicare can choose to get medical care directly from the government-administered Original Medicare program or from private insurance companies under contract with Medicare. More than 80 percent choose the Original Medicare program. Nineteen percent have enrolled in a Medicare private health plan.

Original Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. Medicare Part A is hospital insurance that covers inpatient services, including skilled nursing facilities and hospice care. Medicare Part B is medical insurance that covers outpatient services, including doctor visits, lab tests, durable medical equipment and home health services. Most people get Part A for free, but pay a monthly Part B premium (\$93.50 in 2007). Both Parts A and B have a deductible. Generally, people have to pay 20 percent of Medicare's approved amount for doctor services.

For people who choose to enroll in a Medicare private health plan, Medicare pays the private health plan a set amount every month for each member. Members may have to pay a monthly premium in addition to the Medicare Part B premium and generally pay a fixed amount (a copayment of \$20, for example) every time they see a doctor. The copayment can be higher to see a specialist.

The private plans are required to offer a benefit "package" that is at least as good as Medicare's and cover everything Medicare covers, but they do not have to cover every benefit in the same way. Plans that pay less than Medicare for some benefits, like skilled nursing facility care, can balance their benefits package by offering lower copayments for doctor visits. Private plans use some of the excess payments they receive from the government for each enrollee to offer supplemental benefits. Some plans put a limit on their members' annual out-of-pocket spending on medical care, providing some insurance against catastrophic costs over \$5,000, for example. But many plans use the excess subsidies to offer dental coverage and other services not covered by Medicare and leave members exposed to high medical bills if they fall seriously ill. No one can foresee what type of care they may need in six months. Private plan members can end up with unexpectedly high out-of-pocket costs. And plans that do have a limit on out-of-pocket costs generally are not advertising that benefit, probably because it would attract sicker (and less profitable) members who need more costly care.

In Original Medicare people can buy supplemental insurance to cover Medicare deductibles and coinsurance, which makes their out-of-pocket costs fairly predictable regardless of what medical care they may need. People with low incomes may be eligible for assistance programs, like the Qualified Medicare Beneficiary (QMB) or Medicaid, to cover those costs. People in private health plans, on the other hand, cannot get supplemental coverage for the unexpected out-of-pocket costs they may have to face if they become seriously ill with the "wrong" disease for their plan.

A study by MedPAC found that some Medicare private health plans have high cost-sharing for "nondiscretionary" services such as chemotherapy. For example, looking at the cost of a year of care for a 70-year-old male with advanced colon cancer, the study found out-of-pocket charges of \$7,100 for one plan, \$6,550 for the second plan and \$1,990 for the third plan.²

Similarly, a study by the non-partisan Commonwealth Fund found that out-of-pocket costs for private health plan members vary widely by health status and plan benefit package. The report shows that costs for plan members in poor health would actually have been higher than Original Medicare in 19 of the 88 MA plans examined: "Despite the high payments, relative to fee-for-service [Original Medicare] costs, that MA plans receive from Medicare to enrich enrollee benefits, these plans may not always be a good deal for sicker beneficiaries who use more health services."³

In addition, out-of-pocket costs in private plans can rise substantially from year to year. For example, a study released by AARP in November 2006 found that the average unweighted facility cost for a three-day hospitalization in Medicare private health plans increased 37 percent between 2002 and 2006; for a private health plan enrollee hospitalized for two six-day stays and one three-day stay, the cost increased 59 percent over the same period. In both scenarios, the private health plan rate of increase was substantially higher than the 17 percent increase in the Original Medicare hospital deductible over the same four-year period.⁴

Some Medicare private health plans also offer case and disease management, nurse advice lines and utilization management. The Center for Studying Health System Change has been monitoring these services since 1996 as offered by commercial health plans in 12 cities. The group's experts found no "credible evidence on what impact they have on costs, quality and outcomes."⁵

In Congressional testimony this month, Peter Orszag, the director of the Congressional Budget Office, noted that private insurers have higher administrative costs than the government Medicare program "because of their smaller scale of operations and their costs associated with network development and retention, care management, marketing, and reinsurance."⁶

The burden of high administrative costs (generally 10 to 15 percent for private health plans⁷ compared to 3 percent for Original Medicare) adds to the strong incentive private insurers have to limit access to benefits: members who do not use services cost companies less and increase profits. Orszag put it this way: "As a result, private plans can provide Medicare services at a lower cost than the FFS [Medicare] program only if they can achieve savings through lower utilization or reductions in payment rates for providers that more than offset their higher administrative costs."⁸

When Medicare officials announced in April 2007 that private plans would receive a 3.5 percent raise in reimbursements in 2008, financial analysts predicted that shareholders would reap the benefits. The news, for example, boosted the share price of Humana, which derives almost half its earnings come from its Medicare contracts. About a quarter of WellCare's revenue comes from Medicare, and its share price increased as well.⁹

Common Problems People in Medicare Private Health Plans Face

The problems people have in Medicare private health plans (also known as Medicare Advantage plans) are numerous. Many people discover these flaws only after they have joined the plan—and most cannot switch until the following year.

Most of the cases MRC handles fall into the following categories:

- 1. Care can cost more than it would under Original Medicare;**
- 2. Private plans are not stable;**
- 3. Difficulty getting emergency or urgent care;**
- 4. Continuity of care is broken;**
- 5. Members have to follow plan rules to get covered care;**

6. **Choice of doctor, hospital and other providers is restricted;**
7. **Difficulty getting care away from home;**
8. **Promised extra benefits can be very limited;**
9. **People with both Medicare and Medicaid can encounter higher costs.**

Although specific private health plans are named in the case examples below, the problems they highlight are in no way limited to the companies identified. These cases illustrate problems people experience in any of the hundreds of private health plans offered across the country.

1. Care can cost more than it would under Original Medicare.

Medicare private health plans are required to offer a benefit “package” that is at least as good as Medicare’s, but they do not have to cover every benefit in the same way. For example, while Medicare covers 100 percent of the cost of care for the first 20 days a person requires skilled nursing facility care, a private plan can require members pay a copayment each day they are in a nursing home. Because of this, some people can pay more in a private plan than they would have under Original Medicare.

True Story

Mr. M., who lives in Somerset, New Jersey, enters a hospital every 14 days for three days of chemotherapy treatments for colon cancer. His doctor has ordered four such rounds of treatment. Depending on how his cancer responds, he may require more. His private plan, Horizon Blue Cross Blue Shield, charges him a copayment of \$900 for each hospital visit. That means Mr. M. will have to pay \$3,600 out of pocket just for his first four rounds of chemotherapy treatments. If Mr. M. was in Original Medicare, he would only have to pay the \$992 hospital deductible once because Medicare covers 100 percent of the cost for the first 60 days of hospital care in a benefit period even if they are not consecutive (a benefit period under Original Medicare ends when the person has been out of the hospital for more than 60 days in a row). (Neither of these charges includes doctor fees.)

If instead of joining the private health plan, Mr. M. had stayed in Original Medicare and bought the cheapest supplemental policy available in his area that covers all his out-of-pocket costs for doctor and hospital services (Medigap plan F for \$1,656 a year), he would have saved nearly \$2,000 just in the hospital charges for his first four chemotherapy treatments. And he would have little or no additional out-of-pocket costs for medical care he receives the rest of the year. (Medigap policies are standardized by law, so the only difference between policies of the same type—like plan F—is cost.)

2. Private plans are not stable.

Unlike Medicare, which has offered guaranteed health care coverage since 1966, private health insurance companies come and go. Companies merge or go out of business. They change the benefits package from one year to the next, including what benefits they cover and what the benefits cost. All of these changes are outside the control of plan members, but they can affect their access to the care they need.

True Story

Ever since Ms. T. had polio, she has relied on a wheelchair to get around. The one she uses now is nine years old, broken and beyond repair. In 2006, her HMO, Empire Blue Cross/Blue Shield, initially refused to pay for a new wheelchair and only relented after she appealed. The plan's benefits covered the full cost of the wheelchair without any copayment. In December 2006, the wheelchair supplier told Ms. T. her new wheelchair would not be ready until January 2007. Because the chair would be delivered in 2007, the plan told her its new benefit structure would apply so she would have to pay 20 percent of the cost—or \$1,065. She paid the supplier a \$150 fee to expedite delivery, but the chair still did not arrive in December. Now she owes the supplier money she cannot afford.

3. Difficulty getting emergency or urgent care.

No one knows when or where an accident or other medical emergency will strike. That is why Medicare law mandates that private plans cover emergency and urgent care regardless of whether the provider is in the plan's network or within the plan's service area. (Urgent care is a sudden illness or injury that needs immediate medical attention but is not life threatening.) However, MRC gets many calls from private health plan members who are being denied payment for out-of-network and even in-network emergency care or are being denied authorization to get urgent care while away from home.

True Stories

Mr. R. of Tennessee is 80 years old. In May of 2006 he joined a private health plan, HealthSpring. In November, he suffered a heart attack and was hospitalized. Mr. R.'s plan denied all claims because he had not gotten prior authorization from the plan to enter the hospital. The hospital bill totals over \$87,000.

Mr. S. was having chest pain and called for an ambulance to take him to a hospital near his New Jersey home. When he arrived, he was diagnosed as having suffered a heart attack and was transferred to a second hospital that was better equipped to care for him. He is a member of Oxford, which denied payment for the second ambulance because he did not obtain prior approval from the plan.

4. Continuity of care is broken.

Health experts have long extolled the importance of continuity of care. This generally means the availability or constancy of the health care provider as the source of care, keeping follow-up appointments with the provider and planning seamless transitions when care changes from one setting to another. Knowledge of a patient's medical and family history and personal preferences are among the important information lost when people have to change their health care provider. Changing in the midst of a treatment can be traumatic and detrimental to the patient's health.

True Stories

Mr. A., who lives in Naples, Florida, had spinal cord surgery, which his Humana plan covered even though the operation was performed by an out-of-network surgeon.

However, when he needed to go back to the same surgeon for follow-up visits, Humana refused to pay and told Mr. A. he had to find another surgeon that is part of the plan's network for his follow-up visits to be covered.

Mrs. S. lives in Miami, Florida, and is receiving cancer treatment at Baptist Hospital, which her son says is one of the best in the area. But when her HMO, Preferred Care, ended its contract with the hospital earlier this year, she was told she would have to go another hospital. When she attempted to switch to a different HMO that still includes Baptist in its network, a representative of the new plan said she had missed the Open Enrollment Period (January 1 to March 31 of every year) and would have to wait to change plans until the end of the year.

5. Members have to follow plan rules to get covered care.

Private health plans generally require that a member's doctor get permission from the plan (prior authorization) before a member get certain procedures, tests or care from a hospital or skilled nursing facility. If a member gets the care without the plan's permission, the plan can refuse to pay for it. If the plan denies prior authorization, the member needs to enlist the doctor's help in appealing the plan's decision in order to get the care.

True Stories

Ms. C. has both Medicare and Medicaid. She enrolled in a Humana Medicare private health plan. She started getting bills from her doctors that had previously been completely covered by Medicare and Medicaid. She learned that her plan was denying the claims because she had not gotten a referral from her primary care physician before going to see her specialist doctors.

Mr. G., who lives in North Carolina, has a brain tumor. His sister called MRC because he was getting denials for his care from his Medicare private health plan, Aetna. Mr. G. is very ill and gets most of his treatment at Duke University Hospital. An MRC counselor was able to ascertain that the care was being denied because Mr. G. had not requested authorization from the plan before getting treatment for his brain tumor.

Mr. A. went to his primary care physician, who told him that he could see a dermatologist without a referral, assuring him that his patients do that all the time. However, Mr. A.'s private health plan, Humana, denied the dermatologist's bill because he had not gotten prior authorization to see a dermatologist.

6. Choice of doctor, hospital and other providers is restricted.

Unlike Original Medicare, most private health plans have a network of health care providers—doctors, hospitals, skilled nursing facilities and others—that members must use in order to receive full coverage (except in an emergency). Health Maintenance Organization (HMOs) generally will not pay for care members get from providers who are not part of the plan's network. Preferred Provider Organizations (PPOs) usually allow members to see providers outside the network, but they have to pay more out of their own pocket for the privilege. Private

Fee-for-Service (PFFS) plans allow members to go to any provider that will accept the plan's terms and fees, but many providers will not.

Plan members may find they cannot go to the specialist or hospital recommended by their doctor, the nursing home they stayed at last time they needed skilled nursing facility care, or other providers of their choice. Problems arise when the provider is not in the plan's network, has dropped out of the network or is dropped from the network by the plan. To add to the problem, while health care providers can drop out of a plan's network at any time, members are usually locked in to the plan for a year.

True Stories

Mr. and Mrs. W., who live near Buffalo, New York, joined Blue Cross/Blue Shield's Senior Blue plan late last year. In February, Mr. W. called MRC because none of his wife's doctors participated in the plan's provider network. A plan salesman neglected to mention that the couple would not be able to choose any doctor they wished to see, which was what they were used to under Original Medicare. A plan representative told Mr. W. that his wife could not go to her regular doctors. The couple wants to drop the plan and return to Original Medicare. But it is too late—they are locked into the plan for the rest of the year.

Ms. H., who lives in Portland, Oregon, contacted MRC in December because she needed knee replacement surgery and her private plan, Kaiser Permanente, told her she would have to wait six months to get it. She was limping and in pain and could not wait that long. She was told this plan had a shortage of orthopedic surgeons in her area. It was only after she filed a complaint with Medicare and the plan that she was able to get the care she needed—three months later.

7. Difficulty getting care away from home.

Many people with Medicare enjoy their retirement by spending time with family in other parts of the country or live part of the year in warmer/cooler climates. Original Medicare allows them to get covered health care anywhere in the country. Private health plans generally only allow members to get care within their service area (except in an emergency).

True Story

Mr. and Mrs. B. are New York residents who spend their winters in Florida. Mr. B. is enrolled in a Medicare private health plan offered by HIP. When Mr. B. needed medical care in Florida, HIP wouldn't pay for it because he got care outside the plan's service area. If he had Original Medicare, his care in Florida would have been covered.

8. Promised extra benefits can be very limited.

People with Medicare who choose to enroll in a private plan often do so to get coverage of some benefits Medicare does not cover, like dental and vision care. These benefits vary widely from plan to plan. People sometimes find that the benefit they joined the plan to get will not cover as much as they thought it would.

True Story

Mr. R., who lives in a New York City suburb, was injured after he was hit by a car. His injuries included broken teeth and a broken jaw. Mr. R. could not eat solid food for seven years after the accident. He was unable to work and could not afford to pay his medical bills because his only income was his monthly Social Security Disability Insurance check. When Mr. R. became eligible for Medicare, he learned that Medicare does not cover dental care. Last year, he attended a meeting sponsored by Oxford and met with a sales representative who assured him that Oxford's SecureHorizons plan would cover the dental treatment he desperately needed. After he joined, he was denied dental care and was told that Oxford only pays for accident-related dental care within a year of the accident.

9. People with both Medicare and Medicaid encounter higher costs.

People with Medicare and Medicaid have virtually no out-of-pocket costs. Medicaid helps pay Medicare deductibles and coinsurance. However, if they join a Medicare private health plan, Medicaid may not help pay any of their out-of-pocket costs.

True Story

Ms. E., who lives in Cincinnati, Ohio, is enrolled in the Qualified Medicare Beneficiary (QMB) program. QMB is a low-income assistance program that has slightly higher income limits than Medicaid and also helps pay an individual's Medicare out-of-pocket costs. Ms. E. signed up for a Medicare private health plan, UnitedHealthcare. She called MRC in February 2007 because she was being asked for a copayment for doctor visits. Since she has QMB, she should not have to pay anything out of pocket. She has also had two bills denied, for a mammogram and an ultrasound, because her doctors did not get prior authorization before performing the services. Her bills now total over \$800.

Conclusion

Medicare private health plans were brought into the Medicare program with the promise that competition and entrepreneurship would lead to better, more cost-effective care. In helping people with Medicare get the health care they need, the Medicare Rights Center has found that all too often private health plans do not deliver what they promise. Even with enhanced payments, private health plans often fail to deliver coverage that a patient could obtain from Original Medicare. Medicare private health plans should not cost taxpayers more than Original Medicare. Congress should level the playing field by making private health plan payments equal 100 percent of what it costs to insure people in the Original Medicare program.

Endnotes

- ¹ “Ignagni: Critics Continue to Ignore the Evidence—Medicare Advantage Plans Providing Beneficiaries Better Benefits at Lower Out-of-Pocket Costs,” press release from America’s Health Insurance Plans (AHIP), November 30, 2006.
- ² “Benefit Design and Cost Sharing in Medicare Advantage Plans,” Medicare Payment Advisory Commission (MedPAC), December 2004.
- ³ “Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?” Commonwealth Fund, May 2006.
- ⁴ “2006 Medicare Advantage Benefits and Premiums,” by Marsha Gold, Maria Cupples Hudson, Sarah Davis, Mathematica Policy Research, Inc., AARP Public Policy Institute, November 2006.
- ⁵ “Commercial Health Plans’ Care Management Activities and the Impact on Cost, Quality and Outcomes,” statement of Debra A. Draper, Center for Studying Health System Change, before the U.S. Senate Committee on Finance, April 11, 2007.
- ⁶ “The Medicare Advantage Program: Enrollment Trends and Budgetary Effects,” statement of Peter R. Orszag, director, Congressional Budget Office, before the U.S. Senate Committee on Finance, April 11, 2007.
- ⁷ “Analyzing the Relationship Between Health Insurance, Health Costs, and Health Care Utilization,” Eric French and Kirti Kamboj, *Economic Perspectives*, 3Q/2002.
- ⁸ “The Medicare Advantage Program: Enrollment Trends and Budgetary Effects,” statement of Peter R. Orszag, director, Congressional Budget Office, before the U.S. Senate Committee on Finance, April 11, 2007.
- ⁹ “Insurers to Get Higher Medicare Payments,” Matthew Perrone, The Associated Press, April 3, 2007.