Medicare Advantage Programs and their Impact on Healthcare

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HINF 5105 American Healthcare System

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April 2021

Executive Summary

Since its induction in 1965, Medicare is one of the leading health insurance programs around the globe with an annual cost of $260 billion. It has been one of the largest changes in health insurance coverage in U.S. history, providing universal health insurance to aged, disabled and poor people. It accounts for about 17 percent of U.S health expenditures, one-eighth of the federal budget, and 2 percent gross domestic production in US. But it has its limitations, like high premium rates. To overcome these high premiums and for a coordinated health coverage option , to provide equal health insurance opportunities, to increase quality and to optimize accountability and greater value in the Medicare program, Medicare advantage plans (Formally Medicare part C) came into existence 25 years back with the specified aims, (1) giving beneficiaries a choice of health insurance plans beyond the fee-for-service Medicare program and (2) transferring to the Medicare program the efficiencies and cost savings achieved by managed care in the private sector. As of today, there are more than 26 million Americans with 60% women are enrolled in Medicare Advantage plans, accounting for about 36 percent of total Medicare beneficiaries in United Healthcare.

History of Medicare Advantage plans- How it started?

A decade after the beginning of “fee for service (FFS)” or Original Medicare, in 1975, the Medicare enrollees were given HMOs as an alternative to convert their benefits into managed, capitated health plans, under provisional Medicare proposal programs. In 1997, President Bill Clinton signed “Balanced Budget Act” and reinforced the demonstration programs into

Medicare Part C and instituted the term “Medicare plus choice” which got changed to Medicare advantage plan in 2003 under the Medicare Modernization act of 2003. This act helped in Part C capitated-fee competitive-bidding process establishment, effective from 2006 to increase sponsor involvement. These changes made the premiums of the Part C program flexible. Apart from MA, Medicare plans introduced dual-eligible (Medicare/Medicaid) plans, PACE plans (which try to keep seniors that need non-medical custodial care in their homes) and COST plans. Various other Medicare Advantage plans (HMO, employer group, SNP, regional PPO, etc.) constitutes 97% of plan C beneficiaries, principally in classic vanilla HMOs. Presently, there are 3,550 plans available under Medicare advantage and on an average an enrollee can select from among 33 plans.

Medicare Advantage Plan Description- What is it?

When someone is eligible for Medicare and they are ready to take their Medicare benefits, there is two types of insurance that are available. One of those types of insurance would be a supplemental plan or Medigap that supplements original Medicare. The other one is called an advantage plan or a replacement plan. Half of the Americans are on supplemental plans and half are on advantage plans. Original Medicare, which consists of Hospital insurance (Part A), which provides FFS payments for admitted in-patient hospital care, skilled nursing services and nursing home care for three days in a hospital; Medical insurance (Part B), which provides payments for many doctors, rehabilitation and surgical procedures, nursing facilities after admittance and for necessary outpatient services such as ER, surgical center, laboratory, X-rays

and diagnostic tests, few preventative remedial services (but not annual physical exams), and specific durable medical equipment and supplies. Some of the Medicare Advantage plans are-

1. "Original Medicare" + Part D, where Part D is Private insurance providing prescription Drug coverage.
2. "Original Medicare" + Medicare Supplement + Part D where Medicare Supplements can be dental services, hearing services or even gym subscriptions.
3. Medicare Advantage Prescription Drug Plans, where Medicare part C $\rightarrow$ Hospital insurance + Medical insurance + Prescription Drug coverage + reduce or limit the risk of out-of-pocket medical cost comprising of transportation to medical appointments, over-the-counter drugs coverage, assistance for daily living and home care etc.

Enrollment and capitation – An annual Medicare Advantage Open Enrollment period from January to March each year is provided during which people on MA can transfer or drop plans. From 2021, everyone can enroll into Medicare advantage plan. This works out great for groups of people who are on Medicare early, under age 65 due to disability or illness. In some states these people cannot get Medigap plan, or the premiums are so high for Medigap plans under 65 that they can't afford it. Also, for people who are not healthy enough to qualify for a Medigap plan as they have missed the opportunity to get a Medigap plan during their six-month open enrollment window for Medigap which is from October 15th to December 7th.

For each beneficiary under any other Part C plan or Medicare Advantage plan, the health plan sponsors are paid a pre-determined amount every month by Medicare which is called as capitation amount. The associated capitated charges for Medicare Advantage or Part C plan is

specific to each county in the United States and a government-managed benchmark/competitive-bidding process determines it after county's average per-beneficiary FFS costs from a previous year as a starting point. The charges are then made neutral after adjusting it lower or higher based on the beneficiary's personal health condition. Typically, Medicare Advantage or Part C health plans are funded by non-profit integrated health delivery systems through bidding systems, which meet the necessary requirements. These bids are compared to the highest amount of a plan paid by Medicare in a county which is pre-established benchmark amount. Beneficiaries pays the difference between the benchmark and the bid in the form of a monthly premium if the plan’s bid is higher than the benchmark, in addition to the Medicare Part B premium. For a lower bid, the plan and Medicare share the difference between the bid and the benchmark and is offered as a "rebate," used by the plan's sponsor to either provide ancillary benefits or decreased costs to beneficiaries.

Before enrollment, a person should consider following factors: Individual budget and personal goals of healthcare coverage as well as physicians involved in the network.

Eligibility criteria – The major eligibility criteria for MA are one must be enrolled into both parts A and B, before joining Medicare Advantage plans and one must live in the plans service area which might be a few local counties around one’s resident county or it can be a statewide network.

Impacts of Medicare Advantage plans

Generally, while choosing for a Health insurance plan, mostly people choose a plan which are cheaper on pocket and without considering future ailments. Medicare advantage (MA) plans are easy to be enrolled into and have almost $0 to $49 premium with numerous ancillary benefits like dental benefits, vision benefits, sometimes haring benefits, like hearing aids and even gym memberships, which feel very lucrative to everyone. One gets to know about its impacts after a certain period. From a patient's perspective, there could be both positive and negative impacts of choosing Medicare Advantage plans over traditional Medicare.

Positive impacts: According to ACHP (Alliance of Community Health Plans) factsheet, following are the positive impacts:

1. MA cost beneficiaries and tax-payers 9.5 percent less than what traditional Medicare cost along with additional ancillary benefits.
2. Improved health outcomes and decreased costs after incentivization of health plans, providers and health systems by MA. Doctors employ those programs when caring for patients in traditional Medicare, thereby providing higher quality care.
3. The quality over quantity narrative is furthered by MA Star Ratings systems, thereby promoting accountability, with about 57% lower needless hospitalization rates. A 25% greater coverage for preventive senior care than the traditional Medicare Plans was made possible.
4. Hassle free and convenient to enroll. One needs to carry only one member ID card instead of a Medicare card, a Medigap card and a plan D drug plan card. In MA plan,

there is mostly a built in Part D Drug plan, which you can present to a doctor, at a hospital or at a pharmacy for the services. Therefore, it prevents confusion.

5. The out-of-pocket maximum limit cap on a beneficiary's spending for Part A and B protects them from spending more than $7,550 for in-network expenses and $11,300 for combined in-network and out-of-network expenses in case of chronic illnesses or sudden illnesses. Once the out-of-pocket limit is reached for an individual under MA plan, the plan pays 100% of medical services for the remainder of the calendar year and is reset for the next year.
6. Lastly, Medicare Advantage plans can include home-care benefits like limited adult day care services, at home meal delivery, transportation to and from medical visits and even home safety modifications into their plan designs.

Negative Impacts:

1. Lower premiums are one of the top reasons people join Medicare advantage plans in the first place. However, MA plans often have more Back-end spending because it is pay-as-you-go system. One pays monthly Medicare Part B premium, and any other additional premium, but it becomes expansive because of using healthcare services with multiple co-pays. So, if one sees his primary care doctor for an issue, he has to pay a copay. If his doctor refers him to a specialist, he will have to pay another copay. And if specialist orders lab tests or diagnostic tests, he will have to pay a copay for each of those, as well. So, though $0 plans are enticing but these plans are not entirely free. In a

year of good health, you may spend a very little but in a year with higher medical usage, you might spend more than you have on a Medigap plan.

Now, if we compare out-of-pocket risk against a Medigap plan. Medigap plans have higher premiums but more predictable spending on the back end. For eg: people with a plan G Medigap do not have any co-pays at the doctor or hospital. This means their maximum out-of-pocket for back-end spending on plan G is $198 for the whole year. whereas on a Medicare advantage plan it could be as high as $7500 in the network and more if you have added network services.

2. Because of absence of standardization like Medigap plans, MA plans set up their own premiums, co-pays, provider network, drug formulary, pharmacy network and out-of-pocket maximum which makes them tricky to compare to make a choice for a suitable Medicare advantage plan.
3. Hospitalization costs more for a 5-day hospital stay. Copays add up very fast for emergency room, Ambulance, diagnostic, hospitalization, and inpatient medication which can become costly to the patient and the federal budget, than it would under original Medicare, particularly during serious medical illness.
4. Getting stuck into Lock-in periods. After joining a MA plan, one generally gets locked into the plan for the calendar year. The plan can only be changed during certain designated or a special election period on qualifying during certain circumstances, such as moving out of state. The lock-in-periods was designed to stabilize the market for the insurance companies. However, the lock-in period is something that many beneficiaries

do not like because if they miss something important during their enrolment, they may not realize this until they are already locked in for the rest of the calendar year.

5. Network Restrictions – With a supplemental plan, there is no network restrictions as it has over 1 million providers nationwide. Medicare Advantage has networks and insurance companies operate networks of healthcare providers in a small area. There are two types of networks: HMO and PPO. HMO networks are typically little smaller than PPO. HMO have certain restrictions that PPO may not, such as referral required, and you can't go out of network coverage unless there is an emergency. Sometimes, when someone has been on an original Medicare and Medicaid plan for a few years, they've gotten used to being able to see any provider that accepts Medicare anywhere in the nation.

   Another network hassle has to do with provider contracting. Currently, medical providers can drop from the plans network mid-year while one is still in his lock-in period and finding another provider for the remainder of that calendar year can be frustrating.

6. Prior Authorization delays – With original Medicare there's rarely a need for prior authorization, however, MA plans seem to require prior authorization much more frequently for certain test procedures as well for surgeries. This can delay the procedure for days or even weeks which can be frustrating and moot the point of insurance.
7. Trouble getting emergency or urgent care due to limited in-network providers. Presence of constraints while selecting physicians, hospitals, and other providers is a kind of rationing to keep high profits for the insurance company but limits patient choice.

8. Some private plans may suddenly terminate coverage because of financially instability. A popular MA plan called “Physicians United Plan” was declared insolvent in Florida in 2014, and appointments were cancelled by doctors. This can be a loss to both patient and provider.

Recommendations for potential solutions

After looking into above mentioned favorable and unfavorable impacts of Medicare advantage plans, my opinion has been inclined towards getting the traditional Medicare, but the increased cost of premium dissuades me. And because of all these shortcomings, many people are switching to Traditional Medicare with Medigap plans. But MA plans have its many advantages, mainly being inexpensive and easy enrollment. There are few recommendations which I believe can prove to be helpful in aligning the MA plans with the present requirements for beneficiaries.

1. Developing dual eligible for enrollees need to be a major focus for MA plans. There is a need to integrate those two programs, Medicare, and Medicare Advantage together for seamless overall experience for a beneficiary. Focus should be on to coordinate better care than they currently are today, looking for solutions where we can integrate the various state and federal programs together.

2. In emergency cases, Medicare advantage plan beneficiaries should have an option to go out of network coverage and such cases should be considered for immediate treatment beyond rationing, in terms of providing urgent care and drug treatment.

3. The system of numerous co-pays at every service level and pre-authorization for needed surgical procedures should be modulated. It should be such that the co-pay can be a consolidated amount for a single visit to a facility. A beneficiary should not need to shell out money every time for going to different specialists in a single visit.

4. The switching period from MA plans to Medicare plans should be extended and made flexible. A single comprehensive tool should be made to Compare all Coverage Options. Classifying changes should be introduced to a current enrollment mechanism that allows MA companies to provide seamless continuation of coverage for their beneficiaries even after they become Medicare eligible. Provisions should be made to allow passive enrollment for full-benefit dually eligible beneficiaries from a non-renewing integrated D-SNP to another comparable plan.

5. Cost sharing on some of the most expensive prescription drugs should be lowered for enrollees. A real-time benefit comparison tool should be given to part-D beneficiaries, so that they can make an informed decision about lower-cost alternative therapies under their prescription drug benefit plan. Transparency in cost sharing should be introduced for informed decisions.

6. Lastly, telehealth or digital mediums should be encouraged to use for increasing the enrollment into Medicare Advantage plans and education as well, explaining the best

possible insurance options according to personal goals to the potential beneficiaries by Standardizing and Modernizing Educational Materials for Current and Prospective Beneficiaries.

Analysis of Recommendations

The American healthcare insurance system is a bit complicated and with options like Medicare and Medicare Advantage, there are numerous options available for Americans to make a choice according to their personal needs and healthcare goals. For healthcare, the fact that it should be affordable, accessible, and qualitative is an important aspect in the present scenario. With covid situation in hand, it is important to make health insurance plans flexible as to accommodate the needs of everyone. Health insurance companies strives to elevate the needs of disadvantaged health insurance consumers and should be interested in sponsoring research into the effect of decision support on economically vulnerable populations.

Medicare advantage plans can adapt few of the Medicare qualities like expanding network coverage and reducing co-pays at every service level, while keeping the premiums and cost-sharing low. These things are totally doable by few policy modifications by CMS, and federal government and having clear alignment with strategy, integration with the business and incentives in mind. Expanding network coverage is going to help both beneficiaries and providers in a way that providers also would not have to worry about treatment options for emergency and urgent care cases. The changes in the cost sharing in part D prescription drug would provide much needed transparency on the out-of-pocket obscured costs for prescription

drugs for seniors and other beneficiaries. This will improve Part D plans' negotiating power with prescription drug manufacturers so American patients can get a better deal. Similarly, star ratings for insurance companies can help in maintaining transparency in cost sharing information, quality, and informed decision by a patient for making a choice. At this point, switching plans is not easy when a patient suddenly discovers a chronic illness in the middle of being enrolled in a MA plan as they have to fill a grilling questionnaire. I believe this process can be made easier and feasible for making patient's life easier.

The above recommendations would make MA lucrative and better than before, and it would advance the federal government's efforts to strengthen and modernize Medicare Advantage plans. The feasibility of executing these recommendations depends on the proper modulation, streamlining regulation guidelines by CMS and federal government's approvals and planning with the goal of reducing unnecessary burden, increasing efficiency, and improving the beneficiary experience. As health care costs increase, and seniors increasingly show evidence of multiple chronic conditions and unmet social needs, the choices become more meaningful for individuals and for the country.

Improved Medicare Alliance calls on policymakers and CMS to maintain a stable growth environment for Medicare Advantage, ensuring that innovations in Medicare Advantage can flourish and that the continuity of the health coverage that millions of Americans depend on should be encouraged.

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