

Buyer Beware!

Is There an Advantage to Medicare Advantage?

Editor's Note: This article is intended to educate you about the myriad products available across the Medicare landscape. Though some plans may appear to be better choices than others, IG Living is not endorsing any specific plan type. Deciding whether a plan is good for you requires close inspection of that plan's benefit structure alongside due consideration of your healthcare situation. Further, readers should realize straightaway that Medicare Advantage (MA) plans are not the same as supplemental plans (Medigap). Clarifying this is crucial to resolving much of the confusion surrounding plan choices. To understand the difference between the two, please see "A Plethora of Choices" on Page 28.

By Amanda M. Traxler

Sandy, who has common variable immune deficiency (CVID), is not a fan of Medicare Advantage (MA) plans.

"The only thing I have to say about an Advantage plan is that you are going to get cheated at some point," Sandy said. "There's no way around it."

A strong statement, her sentiment is understandable given an unannounced plan change in 2007 that left her with thousands of dollars in bills.

In 2008, Sandy was able to switch to a supplemental (Medigap) plan, which is what she thought she had in the first place.

Sandy's not alone in her frustration. Many consumers and healthcare advocates are criticizing MA plans. Much of the attention is falling on one plan in particular—

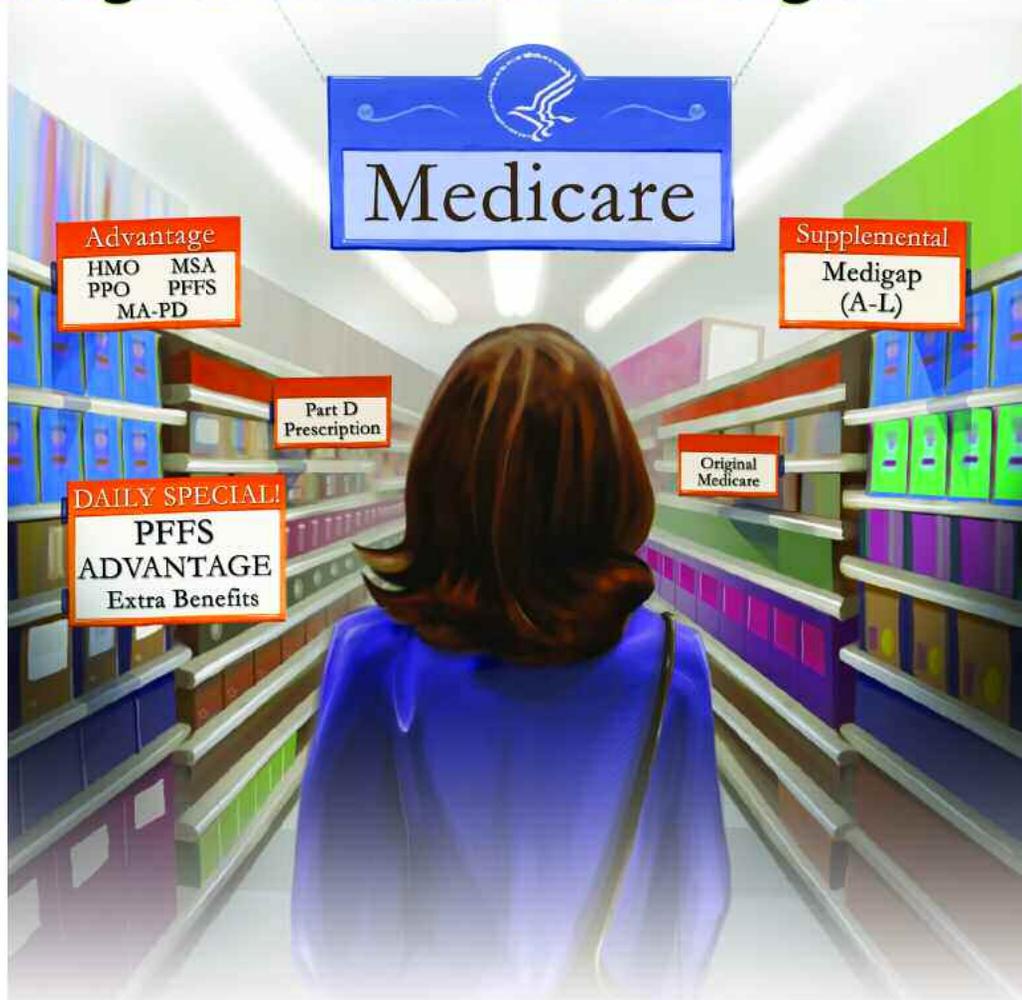
private fee for service (PFFS), which is also one of the fastest-growing plans on the market.

But does that mean a blanket statement can be made, in that, just because Sandy had a horrific experience with an MA plan, that all MA plans are bad?

The situation is too complex to extrapolate a hard-and-fast truth from Sandy's story. In reality, consumer experiences in MA plans run the gamut—ranging from individuals in plans that meet their healthcare needs, to a woman who was signed up for a plan without her knowledge and had to fight months to disenroll,¹ to Sandy, who thought she had bought a Medigap supplemental plan, but who'd actually purchased an MA plan.

What, then, can be concluded?

First, consumers must realize that the diversity of MA plan



types is astounding, with benefits and cost-sharing varying significantly. Take, for example, that some MA plans include prescription coverage (eliminating the need for Part D)—which many consumers find attractive. This alone is why many choose MA plans versus going with Original Medicare, a supplemental (Medigap) plan, and a Part D prescription plan.

This diversity is considered a plus by many, but there's also a flip side to it—namely, confusion, says Dave Evans, CFP and senior vice president of the Independent Insurance Agents & Brokers of America.

“There's definitely a fair amount of confusion,” Evans said. “It's a question of where you sit in terms of the plethora of choices.”

And where one sits in terms of choices has a lot to do with one's individual healthcare needs. An MA plan that is right for patient A may not be right for patient B. And when it comes to patient IG, extra care must be taken when choosing a plan, as coverage will depend on one's diagnosis, treatment site, and whether one uses subcutaneous immune globulin (SCIG) or intravenous immune globulin (IVIG).

No doubt about it: The burden here sits squarely on consumer shoulders to research plan choices carefully.

Further, consumers must also be aware of another issue currently plaguing MA plans: unscrupulous sales tactics that some agents have been using, including false promises, “to market Medicare-related products with little or no concern for the needs of the consumer.”²

On a less-sinister note, even well-intentioned salespersons may not understand the specifics of a plan they're selling: for example, “that a beneficiary's co-payments may be higher than in traditional Medicare.”³

Or, from an IG patient's perspective, that an MA plan's out-of-pocket cost of IG (which can vary from zero to 25 percent and can change when a plan changes) will far outweigh the financial savings incurred from the MA plan's cheaper monthly premiums. (Please see the sample chart on Page 29 for an example of this.)

A lot to stay on top of? It sure is.

Sandy's Story

According to Sandy, her eligibility for disability coverage came through in the nick of time: Diagnosed in 2003, she had just moved to a new state. After becoming eligible for Medicare, Sandy went to the state's biggest HMO provider.

“I went to our local senior center and listened to the presentation,” Sandy said. “And what I thought I was buying—the way they explained it and everything—was supplemental insurance to my Medicare. And of course, I had no prior experience before this about this insurance or anything else

about it.”

For the first few years, things went smoothly.

“From 2003 until 2006 they pretty well paid my IVIG. They [infusions] were done in the hospital. I would go down to the hospital every three weeks and have IVIG.”

In 2007, things changed.

“In 2007, all of a sudden, we weren't getting EOBs [explanation of benefit statements]. We weren't getting any information on where we stood with the medications, and it just became a nightmare, and they were charging me 20 percent of whatever, and I couldn't get them to talk ➤

How to Find a Plan

Contact your State Health Insurance Assistance Program (SHIP), which can provide one-on-one health insurance counseling to Medicare beneficiaries.¹⁶ Each state's SHIP often has specific information about plans in your area; to find your state's office, go to www.medicare.gov/Contacts/static/allstatecontacts.asp.

Use Medicare.gov, which offers a Medicare Prescription Drug Plan Finder as well as a tool that finds and compares supplemental (Medigap) policies.¹⁷ The drug plan finder can also be accessed at 1-800-MEDICARE. Again, take care when searching, as the toolbar for Medigap plans is right next to the toolbar for Medicare Advantage plans.

Use an independent agent to help determine plan options versus one who is selling a specific company's policies. Because independent agents are typically mainstream agents, make sure to find one who specializes in what you're looking for, whether Part D, supplemental (Medigap), or Medicare Advantage coverage. If your insurance agent doesn't sell Medicare-related policies, ask if he or she can recommend someone; or ask friends or other family members who have Medicare policies if they can recommend an agent.¹⁸ According to Dave Evans, CFP and senior vice president at the Independent Insurance Agents and Brokers of America, “one of the most important elements that an independent agent can bring is choice and customization.” Evans advises that consumers should ask how familiar an agent is with Medicare coverage: “The first thing I would do is to ask [the agent] ... how much do they do in this arena.” If they're dabbling in it, Evans said, they're not going to bring a wealth of experience.

Questions to Ask

To find out about coverage, call a plan and ask these questions. Further, remember to keep up to date on this information even after you've enrolled, as plans can change.

Is IG covered? If there's a formulary, use the following J Codes to determine if your brand is on it. Remember, a plan may change a formulary at any time; ask how often it updates its formulary.

- J1561 Gamunex
- J1562 Vivaglobin
- J1566 Lyophilized Powder (Gammagard S/D, Carimune N/F)
- J1568 Octagam
- J1569 Gammagard Liquid
- J1572 Flebogam
- Q4097 (J code coming) Privigen

What site of care is covered? A provider may limit site of care. For example, it may cover only certain locales such as a homecare company or a specific specialty pharmacy. If your physician has an infusion suite, or if your site of care is a hospital, check that these are covered.

What is the coverage for your diagnosis? Ask your doctor for your ICD9 code (your diagnostic code). Once you have the diagnostic code, you can call the insurance company to find out what is covered.

to me. I'm not exactly a stupid person but I couldn't figure out what I was supposed to be paying 20 percent of."

Shortly thereafter, Sandy learned she didn't have the plan she thought.

"Then I found out they [the insurance company] didn't even have a supplemental plan when I became eligible for Medicare and bought a plan. I was flat lied to because they did not even have a regular supplemental plan until 2007."

Though her plan wasn't called an MA plan, Sandy believes it falls in the same category.

"What I found out is that I had a Cost Plus plan, which is, as far as I can tell, very similar to what other companies call Advantage plans." (According to the nonprofit Henry J. Kaiser Foundation, a Cost plan is a type of MA plan.⁴)

If Sandy had been in traditional Medicare, which she was no longer officially enrolled in given that she'd chosen a Cost Plus plan, 80 percent of her IVIG would have been

covered. A true Medigap/supplemental plan (which, again, is what Sandy thought she had) most likely would have picked up the other 20 percent. (Two of the 12 options, K and L, would have picked up only 50 percent and 75 percent of that extra 20 percent, respectively.)

In 2008, Sandy was able to switch into a true Medigap policy. What happened in 2007, however, has had dire financial consequences. And because the provider was charging 2 percent interest per month, or 24 percent APR, Sandy decided to pay what the company said she owed.

"What this company is doing is they are charging people who can't pay interest. I never did quit paying," Sandy said. "The interest just keeps ballooning, and you can't get ahead of it, you can't pay it off. I kept working with them and, finally, they let me pay \$4,000 or \$5,000 and they dropped the interest. But up to that point, I had to do that because here we were at almost \$10,000. It kept ballooning."

In 2008, Sandy appealed. Her first two appeals failed. Currently, she is waiting to appeal a third time before the Department of Health and Human Services.

Her mood, however, is grim.

"I really don't expect it to happen, to be honest with you. They just flat-out charge you whatever they want to charge you. You can't do anything about it."

The Theory Behind MA Plans

The policy on which MA plans are based had a specific intent: provide access to health maintenance organizations (HMOs).

"Medicare Advantage ... builds on prior policy efforts that aimed to establish private plan options in Medicare intended to operate in a competitive marketplace. Its original intent is to provide access to health maintenance organizations (HMOs)."⁵

Opening Medicare to the market force of competition would also, in theory, benefit the patient through improved healthcare.

"One rationale for Medicare Advantage is that its focus on networks and decentralization would encourage greater innovation and more localized structures better suited to managing care than is available from a centralized model."⁶

However, overall benefit structure was not meant to be altered profoundly—as the benefits of MA plans are supposed to be the actuarial equivalent of those provided under Medicare.⁷

That being said, private insurers still have a large say in deciding what those benefits are.

"Under MA, Medicare continues to exercise overall oversight on policy, but it delegates substantial authority to private firms to configure the benefits they offer, determine

provider access, and develop structures and processes to improve quality and care management. MA also provides beneficiaries with diverse plan choices regarding how they receive Medicare benefits.”⁸

Some plans do offer benefit structures that carry out the original intent. Responding to a healthcare blog about MA plans, one employee of an MA-PD HMO plan wrote glowingly about hers: “Our plan is designed and directed by physicians within each community we serve. We clear the roadblocks for our members by empowering our physician partners to make the most appropriate care decisions for their patients, and we afford them time to provide true care coordination and focus on patient long-term health. We consistently have the lowest out-of-pocket costs of any competing plan and we offer additional benefits beyond Medicare such as dental, vision and transportation to and from the doctor. I believe our approach is what MA was intended to be, i.e., a private company that can offer more benefits and drive better health outcomes but do so more efficiently and effectively. Not all MA plans are created equal, but I think it is important to not throw the baby out with the bath water here. A clear distinction needs to be made between Medicare Advantage PFFS plans and Medicare Advantage HMOs. There are countless seniors, most of which are on tight fixed incomes, who benefit from MA-PD HMOs, and I hope our legislators continue to make a clear distinction going forward.”⁹

The employee is right, a clear distinction is needed. Because just as there are those who may be benefiting from the plan mentioned above, there are also those—such as Sandy—who are not benefiting in the slightest.

Choices Gone Wild

To Sen. Tom Coburn, R-Okla., the vast array of MA plans offers seniors personal choice and control over their healthcare decisions.¹⁰ Pretty much no one argues the choice part.

“There is no doubt that MA has expanded the number and types of plan choices available to Medicare beneficiaries. Virtually all Medicare beneficiaries, including those in rural areas, now have some choice of an MA plan. The vast majority have access to plans under at least three contract types (PFFS, MSA, R-PPO).”¹¹

Many critics, however, vociferously oppose his next contention, arguing that the overwhelming number of benefit structures—which often leads to confusion about benefits—virtually negates a beneficiary’s control over healthcare decisions.

As healthcare blogger Maggie Mahar points out, “But if benefits aren’t transparent, how can seniors make a real choice?” ➤

Enrollment Periods¹⁹

Enrollment periods in and of themselves can be confusing. Below is an overview of each period; for more thorough information, please visit www.medicareadvocacy.org/Medicare_EnrollmentPeriods.htm.

Annual Coordinated Election Period (AEP): Nov. 15–Dec. 31
Beneficiaries may change prescription drug plans, change MA plans, return to original Medicare, or enroll in an MA plan for the first time. Changes take effect on Jan. 1.

General Enrollment Period (GEP): Jan. 1–March 31
Medicare beneficiaries who did not enroll in Part B when they first became eligible for Medicare may elect Part B coverage effective July 1 of the same year.

Open Enrollment Period (OEP): Jan. 1–March 31
Medicare beneficiaries may enroll in, disenroll from, or change an MA plan. Unlike enrollment in Part B, the change in MA enrollment or disenrollment becomes effective the month after the change is made. Only beneficiaries who are eligible to enroll in an MA plan may make a change. Beneficiaries may not add or drop Part D. Those who already have drug coverage can only change to another option with drug coverage. Those who do not have drug coverage may not change to an option that provides it. Permissible changes include:

- MA-PD to a different MA-PD
- MA-PD to Original Medicare and a PDP
- Original Medicare and a PDP to an MA-PD
- MA-only plan to a different MA-only plan
- MA-only plan to original Medicare
- Original Medicare to an MA-only plan

Special Enrollment Period (SEP): Variable Time Frame
SEPs allow enrollment changes outside of the GEP, the AEP and the OEP for certain circumstances. Beneficiaries who delay enrolling in Part B because they are covered by employer-sponsored health insurance as an active worker or as a dependent of an active worker are not limited to enrolling in Part B during the GEP. They have an eight-month SEP from the time they (or their spouse) retire or they lose coverage. Part B coverage starts the month after the election is made, and there is no late premium penalty. Other SEPs exist for MA and PDP enrollment and disenrollment. CMS has the authority to create SEPs for exceptional circumstances.

Many opponents are specifically attacking the PFFS plan, which Congress has voted to phase out by 2011—but which is still one of the fastest-growing types of MA plan.¹²

According to Mahar, one problem with these plans is that benefits may change from year to year (which is what happened in Sandy's case). Other concerns about PFFS plans include:¹³

- Many doctors and hospitals don't accept PFFS plans, which can limit choice and access to care.
- Though PFFS plans offer additional benefits, such as hearing aids or eyeglass coverage, other important benefits can be modified (such as limited hospital days or higher co-pays for nursing homes than Medicare). Retirees who require more medical care may be worse off under the plan.
- PFFS plans more frequently deny claims to hold down costs.
- Appeals processes are more difficult under private plans. No longer enrolled in traditional Medicare, beneficiaries

must go through the company rather than Medicare's transparent appeals process.

- The plans are not stable, which means that they can and do pull out of markets, disrupting healthcare services for beneficiaries.

Industry Action

Both Medicare and the insurance industry are aware of these problems. In May, Leslie Norwalk, the acting administrator of the Center for Medicare & Medicaid Services (CMS), announced a requirement that PFFS plans would have to start calling beneficiaries prior to enrollment to ensure that they understand the plans and have decided to enroll in them. Norwalk also said that CMS allows Medicare beneficiaries to leave plans in which they enrolled because of unethical or illegal practices by sales agents and penalizes health insurers involved with the

A Plethora of Choices

Distinguishing among supplemental (Medigap), Medicare Advantage (MA), and Part D prescription plans (which can be stand-alone Part D plans or MA-PD plans) is important.

Part 1: Supplemental Plans (Medigap)

According to AARP.org, a supplemental plan is coverage that will help pay some of the costs in the Original Medicare program and for some care it doesn't cover. Private insurance companies sell Medigap policies. By law, companies can offer only 12 standard Medigap insurance plans (A-L); while all 12 cover basic benefits, each plan has different additional benefits. However, all plans with the same letter cover the same benefits. Though premiums may vary, all Plan C policies will have the same benefits. Supplemental plans do not include long-term care to help you bathe, dress, eat or use the bathroom; vision or dental care; hearing aids; private-duty nursing; or prescriptions.

Part 2: Medicare Advantage Plans (MA)

The first thing to realize about MA plans is that enrolling in Medicare Advantage effectively disenrolls one from Original Medicare Part A and Part B.

"A Medicare Advantage plan replaces traditional Medicare altogether and usually limits a member's choice of doctors and hospitals."²⁰

Beyond that, here's what the government says about MA plans:²¹ MA plans are health plan options that are part of the Medicare program. If you join one of these plans, you generally get

all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. MA plans include:

- Medicare Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Private Fee For Service Plans (PFFS)
- Medicare Special Needs Plans (SNP)

When you join an MA plan, you use the health insurance card that you get from the plan for your healthcare. In most of these plans, generally there are extra benefits and lower copayments than in the Original Medicare plan. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services.

Part 3: Medicare Part D

According to the Center for Medicare Advocacy, the Medicare Part D program, which began in January 2006, provides beneficiaries with assistance paying for prescription drugs. Unlike coverage in Medicare Parts A and B, Part D coverage is not provided under traditional Medicare. Instead, beneficiaries must affirmatively enroll in one of many hundreds of Part D plans offered by private companies.²²

Part D is where you hear about the doughnut hole—another area that is ripe for confusion. "The way the doughnut works, that's not logical," Evans said. "We're all used to as things go up, eventually the plans pays for it. But the way the doughnut was designed, you have this gap. It's a political design to fit the cost."

Sample Comparison of Premium and IG Costs in Original Medicare (With a Medigap and a Part D Plan) vs. a Medicare Advantage HMO With Part D

The sample figures below are based on 2008 rates and were obtained from www.Medicare.gov through a plan search. Intentionally simplified, this chart only compares premium and IG costs and does not account for the doughnut hole or other copays and coinsurance. For the MA example (on the right), three plan examples are given with covered out-of-pocket expenses ranging from zero to 20 percent. Further, a \$5,000 monthly cost is assumed for IG treatment. For specific fees on actual plans, please visit www.Medicare.gov. Once there, enter your IG brand for more-exact estimated monthly costs.

Original Medicare, Medigap, & Part D (monthly)		MA HMO with Part D (monthly)		
		20%	10%	0%**
Part A & B	\$96	HMO \$100 Part B \$96	HMO \$100 Part B \$96	HMO \$100 Part B \$96
Supplemental (Medigap)	\$175	N/A	N/A	N/A
Part D	\$25	N/A	N/A	N/A
IG Costs*	\$0	\$1,000	\$500	\$0
Premiums and IG	\$296	\$1,196	\$696	\$196

* Medigap A-J should cover the 20 percent gap that Medicare A and B do not cover; plans K and L pick up 50 percent to 75 percent of the 20 percent gap respectively. This chart assumes 20 percent gap coverage.

** An MA plan that charges 0 percent out of pocket is hard to find.

practices with fines, suspensions of enrollment or revocation of the ability to sell PFFS plans.¹⁴

The insurance industry has also agreed that stricter marketing guidelines are advisable. However, some question whether the proposed guidelines go far enough, as they do not limit “the commissions that agents get for selling private Medicare plans, which underlie the drive to sign up customers and are fueling Medicare marketing abuses, several critics charge.”¹⁵

Though a good sign that both Medicare and the insurance industry recognize a need for change, there’s still no guarantee that it will be effected anytime soon. Given that, the onus largely falls on the consumer to avoid a bad plan choice. For those looking for plans, one theme emerges loud and clear: Buyer beware! And, when doing your shopping, it might not hurt to keep this article with you. ■

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