Retiree Auto Enrollment in Medicare Advantage Plans – Choice is Under Threat

October 14, 2021

Increasingly, employers and unions that offer retirement health benefits are contracting with private insurance carriers to provide group Medicare Advantage benefits in place of traditional (or original) Medicare. The Center for Medicare Advocacy has heard from numerous dissatisfied beneficiaries faced with automatic enrollment in these types of plans; meaning, their former employer or union will automatically enroll them unless they affirmatively opt out, and as a result, in many cases, pay higher premiums. Some beneficiaries are concerned with their lack of choice. Others are disappointed by the coverage. Here is how one retiree expressed her quandary as the 2021/22 Open Enrollment Period approached:

> … as a retired teacher, I need to make a choice between the United Health Medicare Advantage plan (premium $80 a month) vs. the United Health Care "Group Senior Supplement Plan" (premium $319 per month). I am currently on Anthem Medicare Supplement plan, but the Teachers' Retirement Board is switching everyone to one of these United Health care plans. After dealing with[my husband's] United Health Care Insurance [sic], I'm not happy about this choice. My question to you is: Would the much higher premium be worth it or should I switch to the Medicare Advantage plan? Many or my teacher friends are asking the same question and I'm coming to you for guidance.

Automatic enrollment of Medicare-eligible beneficiaries into employer or union-sponsored group MA plans is a concern; among other things, it limits care options for millions of people and erodes the Medicare statute's protection of choice.

Overview

There are 62.7 million Medicare beneficiaries nationwide in 2021. [1] 26.4 million, or 42% of the total Medicare population, are enrolled in MA plans. [2] Of beneficiaries in MA plans, approximately 20%, or 4.9 million, are enrolled in employer or union-sponsored group MA plans.[3] This represents greater than a 50% increase over the past decade: In 2010, only 1.9 million beneficiaries were enrolled in employer or union-sponsored group MA plans.[4] Data is not available about what percentage of beneficiaries in employer or union-sponsored group MA plans elected to enroll versus were automatically enrolled.

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[1] *Medicare Advantage in 2021: Enrollment Update and Key Trends*, KAISER FAMILY FOUNDATION (June 21, 2021), available at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.
[2] *Id.*
[3] *Id.*
[4] *Id.*

One example of automatic enrollment is the upcoming January 1, 2022 group enrollment of 245,000 New York City retirees (minus whatever number choose to opt out) into an MA plan—all of whom are currently enrolled in traditional Medicare. [5] This group enrollment is the result of an agreement reached between the union and the city that will save the city approximately 25% of what it is currently spending for supplemental (Medigap) insurance for the same retirees.[6] The situation has gained media attention, and the city is being criticized for "forcing" its retirees out of traditional Medicare.[7] Retirees anticipate increasing out-of-pocket costs and decreasing health provider options.[8]

The Law

Medicare Part C, authorizing a set of private Medicare plans, was passed in 1997 (then known as "Medicare+Choice" plans; now known as Medicare Advantage) with the clear intention that traditional Medicare would remain the default option for beneficiaries, who would gain the option of electing potentially more comprehensive privatized plans. The Medicare Act now states that beneficiaries are "entitled to elect" to receive benefits through an MA plan.[9] The statute goes on to say that individuals who fail to make an election for an MA plan during their initial election period are "deemed to have chosen" traditional Medicare.[10] When former President Clinton introduced the legislation, he described the intention in allowing MA plans as "giv[ing] beneficiaries more informed choices among competing health plans."[11]

The Medicare Act refers to the process for enrolling in MA plans as the "process for exercising choice."[12] Generally, an individual is required to fill out and file an appropriate election form to enroll.[13] The statute lays out one clear exception to this individualized, choice-based enrollment process via a provision titled, "Seamless continuation of coverage."[14] The provision allows for the Secretary of the Department of Health and Human services to establish a procedure for automatic enrollment of individuals who are, at the time they become Medicare-eligible, enrolled in a health plan offered by an insurance carrier that also offers MA plans.[15] Those who fail to make an election can be automatically enrolled in the MA plan offered by their carrier.[16] Despite the extent of this authority, a final rule was issued in 2018, narrowing the scope to individuals

[5] *Stop the Medicare bait-and-switch: NYC is posed to harm its retirees*, N.Y. DAILY NEWS (August 13, 2021), available at https://www.nydailynews.com/opinion/ny-oped-stop-the-medicare-bait-and-switch-nyc-retirees-20210813-tjvtnjf3vbaermqb4x32cbw63e-story.html.
[6] *Id.*
[7] *Id.*
[8] *The New York City Union Whose Backdoor Deal Sold Out Retirees, Helped Insurance Industry*, NEWSWEEK (June 28, 2021), available at https://www.newsweek.com/new-york-city-unions-whose-backdoor-deal-sold-out-retirees-helped-insurance-industry-1604661.

[9] 42 U.S.C. § 1395w-21(a)(1)
[10] 42 U.S.C. § 1395w-21(c)(3)(A)(i)
[11] 1997 U.S.C.C.A.N. 677-1, 1997 WL 806821 (Leg.Hist.)
[12] 42 U.S.C. § 1395w-21(c)
[13] *Id.*
[14] 42 U.S.C. § 1395w-21(c)(3)(A)(ii)
[15] *Id.*
[16] *Id.*

dually eligible for Medicare and Medicaid only, with several conditions, including state and CMS approval, and from affiliated Medicaid managed care plans.[17]

The process for automatic enrollment of beneficiaries into employer or union-sponsored group MA plans, on the other hand, is not explicitly authorized by the Medicare Act. Rather, in December of 2000, a provision was added to the statute regarding employer or union-sponsored group MA plans, which gave the Secretary the broad authority to "waive or modify requirements that hinder the design of, the offering of, or the enrollment in [such MA] plans."[18] This provision paved the way for the creation of the automatic enrollment process whereby employers or unions could automatically enroll their retirees into an MA plan so long as they provide advance notice and a mechanism to opt out. This process is outlined in sub-regulatory guidance, which was implemented without the notice and comment period required of federal regulations.[19] The guidance states in relevant part that group enrollment may occur "without obtaining a paper MA enrollment request form from each individual" and that "[t]he enrollment requests reported to the MA organization by the employer/union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan." [20]

Once a beneficiary is enrolled in an employer or union-sponsored group MA plan, as with any other MA plan, they should receive all the same benefits included under Medicare Parts A and B with limited exceptions (*e.g.,* hospice care).[21] However, as discussed below, there are practical disadvantages of MA for many individuals. Further, it is unclear how the authority provided to the Secretary to "waive or modify requirements" has been or will be used to limit benefits.

Reasons for Concern

1. Erosion of Choice

Automatic enrollment in employer or union-sponsored MA plans eliminates the basic protection offered to beneficiaries by the Medicare Act that traditional Medicare will remain the default option and MA enrollment will be an individual's choice. Providing beneficiaries with advance notice and allowing them to opt out of group auto-enrollment in MA mitigates the issue but does not provide real choice. The financial incentives to stay in the MA plan, and the difficulty in choosing otherwise, make opting out unrealistic, even if the group MA plan will not best meet the individual's needs.

Further, due to automatic enrollment, in negotiating these employer and union-sponsored contracts, MA organizations do not need to provide incentives for beneficiaries to opt in by offering more comprehensive coverage. They can negotiate based on the number of beneficiaries who will be automatically enrolled. It seems reasonable to assume this assurance shifts the focus away from benefits and towards cost-saving, as appears is the case for the New York City retirees.

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[17] See final rule CMS-4182-F at 83 Fed. Reg. 16,440 (April 16, 2018), amending 42 C.F.R. § 422.66.
[18] 42 U.S.C.A. § 1395w-27 (West 2003)
[19] Medicare Managed Care Manual, Ch. 2, §§ 20.3.1 and 20.3.3, available at https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf (last visited October 7, 2021).
[20] *Id.*
[21] MMCM, Ch. 4, § 120, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf (last visited October 7, 2021).

2. Lack of Access to Medigap Plans

Some retiree coverage offered by former employers or unions is similar to Medicare supplemental insurance (*i.e.*, Medigap insurance) in that it acts as secondary insurance to traditional Medicare by covering some of Medicare's cost-sharing and can provide some extra benefits not provided by Medicare. As noted above, however, more employers and unions are shifting retirees into MA plans. In 2021, nearly one in five MA enrollees are in such group plans.[22]

Unlike with MA plans, in which beneficiaries can enroll and disenroll annually, rights to purchase Medigap plans are limited in most states. Under federal law, there are limited opportunities beyond the first six months someone age 65 or over is first enrolled in both Parts A and B; there are no federal rights to purchase a Medigap plan for beneficiaries under age 65. States can expand rights to purchase Medigap plans, but only four states (Connecticut, Massachusetts, Maine and New York) require some type of annual or continuous enrollment right.[23] This means that in all other states and D.C., outside of a few triggering events or scenarios, beneficiaries who disenroll from an MA plan and return to traditional Medicare may be denied a Medigap policy due to a pre-existing condition.

3. Other Disadvantages of Medicare Advantage

There are various pros and cons to consider when evaluating traditional Medicare against Medicare Advantage.[24] On the one hand, MA plans might offer some benefits not covered by traditional Medicare, and often charge less in monthly premiums than Medigap plans and stand-alone Part D prescription drug plans. On the other hand, most MA plans use restricted networks of providers and virtually all MA enrollees are in plans that require prior authorization for many services (especially for relatively expensive services).[25] Such use of prior authorization often leads to problems accessing services; a 2018 government report found, for example, "widespread and persistent problems related to denials of care and payment in [MA] plans".[26] Further, although MA plans are required to have a maximum out-of-pocket (MOOP) limit for covered Part A and B services, MA enrollees can pay more in out-of-pocket expenses for their care than beneficiaries in traditional Medicare.[27]

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[22] *Medicare Advantage in 2021: Enrollment Update and Key Trends*, KAISER FAMILY FOUNDATION (June 21, 2021), available at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

[23] See, e.g., *Medigap News: Disparities in Enrollment Rights; Bill Introduced to Strengthen Medigap Access and Protections*, CENTER FOR MEDICARE ADVOCACY (July 19, 2018), available at: https://medicareadvocacy.org/medigap-news-disparities-in-enrollment-rights-bill-introduced-to-strengthen-medigap-access-and-protections/.

[24] See, e.g., *Choosing Between Traditional Medicare and Medicare Advantage*, CENTER FOR MEDICARE ADVOCACY (January 1, 2013), available at https://medicareadvocacy.org/choosing-between-traditional-medicare-and-a-medicare-advantage-plan/.

[25] *Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits*, KAISER FAMILY FOUNDATION (June 21, 2021), available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/.

[26] *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL (2018), available at https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[27] See, e.g., *Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, KAISER FAMILY FOUNDATION (June 25, 2021)

Quality of care in MA plans is also of great concern. As noted in a 2018 *New England Journal of Medicine (NEJM)* article, research shows that the evidence is mixed—for example, there are generally higher rates of preventive care and screenings among MA recipients, but "[s]omewhat counterintuitively, there seems to be no difference between Medicare and [MA] plans with respect to care coordination" and "[s]everal studies have flagged concerns about the quality of care received by high-need, high-cost enrollees, on the basis of disenrollment rates and other measures."[28]

As a practical matter, unlike traditional Medicare and most Medigap insurance, MA plans can change their benefits and cost-sharing every year. That means that while a given MA plan might suit someone's needs one year, there is no guarantee that it will continue to do so. Being locked into one plan or plan sponsor through a former employer or union can limit an individual's coverage options.

Conclusion

When Medicare Part C private Medicare plans were introduced in 1997, they were intended to provide an individual choice for beneficiaries; mass automatic enrollment of retirees into employer and union sponsored MA plans was not anticipated. The practice is antithetical to the principle that MA plans would give beneficiaries more choice. Now, even assuming they are properly informed of their right to opt out, beneficiaries are faced with a false choice: (1) Stay enrolled in the auto-MA plan, regardless of their individual needs and the quality of the plan, or (2) Disenroll from the plan and either go without Medigap insurance or be responsible for a higher premium, if Medigap is even available for them.

As the trend of automatic group MA enrollment continues, beneficiaries should be given the right to **opt in,** rather than opt out, of the proposed MA plan. At the very least, CMS should ensure that beneficiaries receive robust education about the proposed plan, the consequences of enrollment, their other options, and an easily accessible way to exercise those options. These requirements would help retain the promise of Medicare Advantage to provide beneficiaries with individual choice, based on their individual needs.

October 14, 2021 – E. Krupa

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available at https://www.kff.org/medicare/issue-brief/cost-related-problems-are-less-common-among-beneficiaries-in-traditional-medicare-than-in-medicare-advantage-mainly-due-to-supplemental-coverage/, (finding that rates of cost-related problems are higher among MA enrollees than those in traditional Medicare with supplemental coverage); and *Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits*, KAISER FAMILY FOUNDATION (June 21, 2021) (see link above), (finding that slightly more than half of all MA enrollees would incur higher costs than beneficiaries in traditional Medicare for a 6-day hospital stay).

[28] *Medicare Advantage Checkup*, NEW ENGLAND JOURNAL OF MEDICINE (NEJM) (November 29, 2018), available at: https://www.nejm.org/doi/full/10.1056/nejmhpr1804089.

