EXPANSIONS OF MEDIGAP CONSUMER PROTECTIONS ARE NECESSARY TO PROMOTE HEALTH EQUITY IN THE MEDICARE PROGRAM

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Introduction

This article will set out how expansions of consumer protections for private Medigap supplemental insurance are necessary to promote health equity in the Medicare program. Currently, individuals over age 65 who enroll in traditional Medicare during their initial enrollment period have only a six-month window in which to purchase a Medigap plan, without health underwriting (screening), that covers the remaining, often substantial, out-of-pocket costs in traditional Medicare. These costs include co-insurance and deductibles. In most states, after the six-month window ends, an individual who decides to enroll in a Medigap plan may be subject to higher premiums because of pre-existing conditions or may be rejected outright by health underwriting (screening). If enrolled in a private Medicare Advantage plan for the first time, then individuals can only have access to a Medigap plan if they switch to traditional Medicare during their first year in the Medicare Advantage Plan, the 12-month trial period. Individuals under 65 who become eligible for Medicare due to permanent long-term disabilities have even fewer protections; Medigap insurance companies may deny coverage for this population completely. The

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variability in state protections is due to the lack of comprehensive federal Medigap consumer protections.

This article will outline the background of Medigap and Medicare Advantage and discuss how the limited federal consumer protections in Medigap create barriers for individuals who wish to exit Medicare Advantage in order to enroll in traditional Medicare. Without the financial protection of a Medigap plan to cover many out-of-pocket costs in traditional Medicare, and without an annual out-of-pocket limit on cost-sharing for services covered under Parts A and B in traditional Medicare, many beneficiaries cannot afford to switch from a Medicare Advantage plan to traditional Medicare, even if Medicare Advantage is not best serving their needs. This article reviews the research on the challenges associated with Medicare Advantage for many older, sicker Medicare beneficiaries, and beneficiaries of color, including problems related to limited provider networks and higher out-of-pocket costs, and the health equity considerations these issues raise. Together, this will demonstrate the link between limited federal consumer protections in Medigap, the forced reliance on Medicare Advantage plans, and the resulting equity concerns. The article will conclude with a discussion of possible federal consumer protections that could reduce some of these barriers and improve health equity. These include expanding guaranteed issue for the under 65 Medicare population and expanding enrollment opportunities. The considerations aim to expand consumer protections while limiting increases in Medigap premiums for all beneficiaries.

Health Equity

At the outset, it is important to outline what "health equity means." While definitions of health equity may vary slightly depending on the source, there are general principles central to all variations. The Office of Health Equity at the Health Resources & Services Administration defines health equity as "the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and

health outcomes such as disease, disability, or mortality."[2] The Robert Wood Johnson Foundation (RWJF), which bills itself as the nation's largest philanthropy dedicated solely to health, provides the following definition, "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[3] Central to this discussion is the understanding that health equity entails recognizing and limiting disparities in treatment, access, or costs of care that are not explained by differences in individual preferences or health status.

Financial Background of Medicare Beneficiaries

Medicare is a social insurance program with a defined benefit, which beneficiaries pay into during their working years. Created in 1965, Medicare provides federal health insurance for people ages 65 and over, regardless of their income. The program was expanded in 1972 to cover certain people under age 65 who have a long-term disability. The total number of Medicare beneficiaries in 2020 reached almost 62 million people.[4] The program helps to pay for many medical care services, including hospitalizations, physician visits, prescription drugs, preventive services, skilled nursing facility, home health care, and hospice care.

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[2] Health Resources & Services Administration, *Office of Health Equity*, HRSA (Oct. 2020) https://www.hrsa.gov/about/organization/bureaus/ohe/index.html.
[3] P. Braveman, E. Arkin, T. Orleans, D. Proctor and A. Plough, *What is Health Equity?* ROBERT WOOD JOHNSON FOUND., (May 1, 2017), https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.
[4] Kaiser Family Foundation (KFF), *Total Number of Medicare Beneficiaries (2020)*, https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Medicare completely changed the landscape of health care access in the country, lifting millions of older adults out of poverty. Medicare's promise is that all older adults can age with dignity and know that they will have fair access to affordable health care, thereby supporting families as well as older adults. Before Medicare's enactment in 1965, only about 50% of older adults had health insurance[5] and about 30% lived in poverty.[6] The guaranteed coverage Medicare provides, regardless of income, medical history, or health status, has enhanced the health and financial security of older people and their families. Because of Medicare, virtually all Americans 65 or older are insured.[7]

Despite all that Medicare provides, there are out-of-pocket costs that are left for beneficiaries to cover. Traditional Medicare has deductibles for Parts A[8] (inpatient) and B (physician and outpatient) services, 20% coinsurance for most Part B items and services, and copayments for inpatient hospital and skilled nursing facility stays exceeding a certain number of days.[9] There is no maximum amount beneficiaries can incur in out-of-pocket costs each year for A and B services in traditional Medicare.[10] As a result, these costs can become substantial.

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[5] Karen Davis, Cathy Schoen & Farhan Bandeali, *Medicare: 50 Years of Ensuring Coverage and Care,* The Commonwealth Fund (April 2015) https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2015_apr_1812_davis_medicare_50_years_coverage_care.pdf.

[6] Ctr. for Medicare Advocacy, 50 Insights for Medicare's 50th Anniversary, (Jan. 2015) https://medicareadvocacy.org/50-insights-for-medicares-50th-anniversary/.

[7] Davis, Schoen & Bandeali, *supra* note 5, finding that in 2015, only 2% of Americans 65 and older had no insurance.

[8] In general, Part A also covers home health care, hospice care, and skilled nursing facility care.

[9] Ctr. for Medicare & Medicaid Serv., (CMS), *2021 Medicare Parts A and B premiums and deductibles*, CMS.GOV (Nov. 6, 2020), https://www.cms.gov/newsroom/fact-sheets/2021-medicare-parts-b-premiums-and-deductibles.

[10] *Medicare & You 2022*, National Medicare Handbook No. 10050, at 6 (Dec. 2021) https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf. While this official government guide is a valuable resource for information, there has been much advocacy among consumer advocates to remove bias toward Medicare Advantage in the Medicare and You Handbook annual iterations, *see* Ctr, for Medicare Advocacy, *MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage*, MEDICARE ADVOCACY.ORG (Sept. 20, 2021),

Background information on Medicare beneficiaries' average income and assets provides helpful context for a discussion of out-of-pocket costs and health care spending. Half of all Medicare beneficiaries had incomes below $29,650 per person in 2019; one quarter had incomes below $17,000 per person in 2019.[11] It is also significant to note the disparities in income and savings based on race and ethnicity. Median per capita income was considerably higher for beneficiaries who were White ($33,700) when compared to those who were Black ($23,050) or Hispanic ($15,600).[12] Median per capita income was substantially lower for beneficiaries under age 65 with permanent disabilities ($19,550) than among older adults. [13]

In 2019, half of all Medicare beneficiaries had less than $73,800 in savings per person, and one quarter of all beneficiaries had savings below $8,500 per person, while 12% had zero savings or were in debt.[14] The percentage of Black (25%) and Hispanic (27%) Medicare beneficiaries with no savings in 2019 was much higher than the percentage of White (8%) Medicare beneficiaries with no savings.[15] Median savings among beneficiaries under age 65 with disabilities ($34,050) were significantly lower than among older adults ($83,850). [16]

Given the limited income and assets for the majority of beneficiaries, particularly for communities of color, the out-of-

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https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid={{ContactsEmailID}}.

[11] Wyatt Koma, Tricia Neuman, Gretchen Jacobson & Karen Smith, *Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic*, KFF (Apr. 24, 2020), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-financial-security-before-the-coronavirus-pandemic/.

[12] *Id*.

[13] *Id.*

[14] *Id*.

[15] *Id.*

[16] *Id.*

pocket costs in Medicare can be crushing. In 2016, the average Medicare beneficiary spent $5,460 out-of-pocket for health care, including premiums, cost-sharing, and expenses for services not covered by Medicare.[17] Women, persons aged 85 and over, individuals who have multiple chronic conditions, and individuals who do not have any source of supplemental coverage had significantly higher expenses than others.[18] Beneficiaries without supplemental coverage were more likely to have lower incomes and be age 85 or older; among beneficiaries with no supplemental coverage in 2016, the average out-of-pocket costs were $7,473.[19]

According to a 2021 Kaiser Family Foundation analysis, the estimated average monthly premiums for Medigap policies, insurance plans that are designed to fill in some of the gaps of traditional Medicare, including deductibles, coinsurance, and copays, range from $150 to around $200.[20] The Medicare Payment Advisory Commission (MedPAC), the nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program, estimated in its "March 2021 Report to Congress" that beneficiary spending on Medicare premiums and cost sharing consumed "24% of the average Social Security benefit in 2020, up from 14% in 2000."[21]

A large percentage of Medicare beneficiaries have supplemental insurance either through retiree benefits, Medicaid for those who meet state eligibility requirements, or a Medigap plan. In 2018, the most recent date for which data is available, most traditional

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[17] It is important to note that Medigap generally only covers cost-sharing for services covered by Medicare. *See*, Juliette Cubanski, Wyatt Koma, Anthony Damico & Tricia Neuman, *How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?*, KFF (Nov. 4, 2019) https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/.

[18] *Id.*

[19] *Id.*

[20] Wyatt Koma, Juliette Cubanski & Tricia Neuman, *A Snapshot of Sources of Coverage Among Medicare Beneficiaries in 2018*, KFF (Mar. 23, 2021) https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/.

[21] MEDICARE PAYMENT ADVISORY COMM'N, 117TH CONG., *March 2021 Report to Congress*, xiv (Mar. 15, 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf.

Medicare beneficiaries (83%), had supplemental coverage, either through Medigap (34%), employer-sponsored retiree coverage (29%), or state Medicaid (20%). Almost 1 in 5 (17%) Medicare beneficiaries in traditional Medicare did not have any supplemental coverage.[22] According to Kaiser Family Foundation, "[c]ompared to all traditional Medicare enrollees in 2018, a larger share of beneficiaries with no supplemental coverage had annual incomes between $20,000 and $40,000, were under the age of 65 (and eligible for Medicare due to having a long-term disability), and were men."[23] Only 5% of Black beneficiaries and 7% of Hispanic beneficiaries have Medigap supplemental coverage, compared to 25% of White beneficiaries.[24]

This article will not explore the other types of supplemental coverage; rather, it will focus solely on Medigap plan access. Despite the robust coverage Medicare provides, beneficiary out-of-pocket costs can be substantial. This financial burden is central to the discussion of Medigap access.

Background on Medigap Plans

Medicare Supplement Insurance (commonly known as Medigap) is an optional form of supplemental insurance offered by private insurers to help pay for out-of-pocket costs beneficiaries face.[25] These can include deductibles, copayments, and other out-

[22] Koma, Cubanski & Neuman, *supra* note 20.
[23] *Id.*
[24] Nancy Ochieng, Juliette Cubanski, Tricia Neuman, Samantha Artiga & Anthony Damico, *Racial and Ethnic Health Inequities and Medicare,* KFF (Feb. 16, 2021) https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/.
[25] *See* Ctr. for Medicaid & Medicare Serv., (CMS), *What's Medicare Supplement Insurance (Medigap)?*, Medicare.gov, http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html; *see also* CMS, *Medigap (Medicare Supplement Health Insurance)*, CMS.gov (Dec. 1, 2021), http://www.cms.gov/Medicare/Health-Plans/Medigap/index.html.

of-pocket costs. Medigap insurance typically covers only services that Medicare has already approved for payment, and generally does not pay for excluded or omitted items and services in traditional Medicare.[26] Medigap coverage is a key component of health insurance protection for individuals who access health care through the traditional Medicare program. Medigap policies help to protect beneficiaries from unexpected high health care expenses, along with providing beneficiaries the ability to more precisely budget for their health care costs. [27]

Medigap insurance is generally regulated at the state level, but federal law requires insurance companies that sell Medigap policies to abide by certain minimum consumer protection requirements.[28] Insurers are required by statute to provide a one-time, six-month open enrollment period for Medigap policies that begins on the first month that a beneficiary is 65 or older [29] and elects Part B coverage. During this period, these beneficiaries must be "guaranteed issue" of Medigap plans regardless of their age, sex, or health status. While they may be subject to higher premiums, a beneficiary aged 65 or older cannot be denied Medigap enrollment by an insurance company during this six-month period.[30]

All Medigap policies must abide by federal and state laws that dictate the structure of benefits and provide consumer protections. Beginning in 1990, the Health Care Financing Administration (HCFA), now the Centers for Medicare & Medicaid Services (CMS), established a program of mandatory certification of 10

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[26] *Id.*

[27] Gretchen Jacobson, Jennifer Huang & Tricia Neuman, *Medigap Reform: Setting the Context for Understanding Recent Proposals*, KFF (Jan. 13, 2014) https://www.kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.

[28] 42 U.S.C. § 1395ss(s).

[29] Many beneficiaries continue to work past age 65, in large part because the age for Medicare (65) is no longer connected to the age for Social Security.

[30] *See* Ctr. for Medicaid & Medicare Serv., (CMS), *How to Compare Medigap Policies*, MEDICARE.GOV, https://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html; *see also*, CMS, Guaranteed Issue Rights, MEDICARE.GOV, https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap/guaranteed-issue-rights.

standard plans.[31] Under this authority, the Secretary of Health & Human Services (HHS) is required to establish a procedure whereby Medigap policies are certified as meeting minimum standards and requirements.[32]

Private insurers selling Medigap policies in most states may only sell consumers standardized policies that are identified by the letters A through N. Regardless of which insurance company is selling a particular plan, all benefits within each plan must be identical.[33] The only difference between Medigap policies of the same letter is that their premiums may differ among insurance companies.[34] The plans are labeled with the letters A through N to make comparing plans more straightforward.[35] Medigap policies pay most, if not all, of original Medicare's coinsurance amounts and some provide

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[31] *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4353(a), 104 Stat. 1388 (Nov. 5, 1990) (codified at 42 U.S.C. §1395ss(a)), applicable to policies sold after July 1992; such policies must conform to one of the 10 standardized model policies developed by the National Association of Insurance Commissioners (NAIC).

[32] 42 U.S.C. § 1395ss(a)(1). The Secretary's authority to promulgate rules for the administration of its certification program for Medigap policies is found at 42 U.S.C. § 1395ss(h). The requirements for certification by the Secretary are found at 42 U.S.C. § 1395ss(c). Procedures for certification are found in the regulations at 42 C.F.R. § 403.232.

[33] Some states have allowed insurers ancillary benefits, which vary widely. *See* NAIC, *2021 Survey of Medicare Supplement New or Innovative Benefits Chart* (July 23, 2021), https://content.naic.org/sites/default/files/inline-files/2021-New-or-Innovative-Benefit-Chart_0.pdf.

[34] In all states except Minnesota, Massachusetts, and Wisconsin, federal law requires insurers to sell Medigap policies that are one of 10 standard supplemental plans. 42 U.S.C. §1395ss(a). For information on these three states' Medigap plans for 2021 as well as the 10 standardized plans, *see* Ctr. for Medicaid & Medicare Serv., (CMS), *2021: Guide to Choosing a Medigap Policy*, MEDICARE.GOV, https://medicarehbs.com/wp-content/uploads/2021/04/2021-Choosing-A-Medigap-Policy.pdf. For additional updates, *see also* National Association of Insurance Commissioners, "Home Page," https://www.naic.org/.

[35] 42 U.S.C. §1395ss(a).

coverage for deductibles as well. Medigap does not cover costs for medical services that are not covered by Medicare.[36]
Many changes have been made to the plans over the years. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added two new standardized plans in 2006 and changed the benefits under three existing plans.[37]

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)[38] made changes to the standardized Medigap policies that may be sold on or after June 1, 2010. MIPPA authorized a reduction in the number of standardized plans offered from 12 to 10. Plans E, H, I, and J were completely eliminated, as Plans H, I, and J became duplicative of other plans after the MMA added a prescription drug benefit to Medicare.[39]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made major changes to those eligible for certain Medigap policies starting in 2020.[40] Beginning in 2020, Plans C and F have been eliminated as a choice for newly eligible Medicare beneficiaries. This includes all individuals whose 65th birthday occurred on or after January 1, 2020, or whose date of eligibility for Medicare occurred on or after January 1, 2020. This includes all

[36] Ctr. for Medicaid & Medicare Serv., (CMS), *What's Medicare Supplement Insurance (Medigap)?* https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap.
[37] Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173 (Dec. 8, 2003), amending 42 U.S.C. §1395ss. The MMA authorized the NAIC to review and revise the model standards to incorporate the new plans and reflect these changes in the existing plans.
[38] MIPPA, Pub. L. No. 110-275 (July 15, 2008).
[39] MMA, Pub. L. No. 108-173 (Dec. 8, 2003). Plan E became unnecessary as a result of the other MIPPA changes. MIPPA also eliminated the "at-home recovery" and "preventive care" benefits from additional benefits Medigap plans could offer. A new hospice benefit, which covers all cost-sharing for Part A eligible hospice care and respite care expenses, was added as a core benefit available with every Medigap plan offered for purchase.
[40] MACRA §401, Pub. L. No. 114-10 (Apr. 16, 2015) (explaining medigap plans D and G are substituted in federal law for C and F for newly eligible beneficiaries, but C and F were not deleted from federal law).

individuals who become eligible for Medicare, whether due to age, disability, or end-stage renal disease.[41]

Those eligible for Medicare before January 1, 2020, but not yet enrolled, may be able to buy one of these plans.[42] Enrollees in Plans C and F prior to 2020 will be able to keep their policies indefinitely and may also change insurance carriers. However, premiums for these plans are expected to rise as the pool of enrollees shrinks.

Background on Medicare Advantage Plans

This paper does not focus on private Medicare Advantage plans or all the changes that have been made to Medicare Advantage over the last few years. Additionally, it does not make recommendations for improving MA plans or oversight. However, in order to fully explain equity issues resulting from barriers to Medigap plan access, background on Medicare Advantage plans, and how those plans serve beneficiaries, is helpful. Some form of managed care has always existed in Medicare; private contracting was formalized through the Balanced Budget Act of 1997 (BBA '97) by adding "Part C" to the Medicare statute and creating the Medicare+Choice (M+C) program.[43] Part C is now known as Medicare Advantage (MA).[44]

Medicare Advantage plans are a type of Medicare health plan that are administered and run by private insurers that contract with Medicare to provide an individual with all of their Part A and Part B benefits. The private Medicare Advantage health plans are

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[41] 82 Fed. Reg. 41, 684 (Sept. 1, 2017), https://www.govinfo.gov/content/pkg/FR-2017-09-01/pdf/2017-18605.pdf (defining "newly eligible Medicare beneficiaries," as well as other clarifications of the MACRA law). For a helpful guide on who is eligible, *see also* Bonnie Burns, Think Advisor, "MACRA and the Medigap Letter Plans" (Nov. 24, 2019), https://www.thinkadvisor.com/2019/11/24/macra-and-the-medigap-letter-plans/.
[42] *See*, CMS *supra* note 30.
[43] Balanced Budget Act (BBA '97) of 1997, Pub. L. No. 105-33 (1997).
[44] *Id*.

approved by Medicare and regulated by the federal government. A Medicare Advantage enrollee will get his or her Medicare Part A, Part B, and usually Part D prescription drug benefits covered through the private plan, not traditional Medicare. The Health & Human Services (HHS) Secretary is required to establish standards, regulations, and rules for Medicare Part C. The private insurance plans are paid by the Centers for Medicare & Medicaid Services (CMS) on a capitated basis to cover the care of their enrollees.

Every year, all Medicare beneficiaries nationally are able to make changes to their Medicare Advantage and Part D plan selections. This is referred to as the annual coordinated election period (ACEP), which runs every year from October 15 through December 7, with changes becoming effective January 1st of the following year. During the annual period, or open enrollment, beneficiaries have the ability to switch from one Medicare Advantage plan to another, can switch from Medicare Advantage to Original Medicare or from Original Medicare to Medicare Advantage, join a Medicare Part D prescription drug plan, switch from one Part D plan to another, or drop Medicare Part D coverage entirely.[45] Medigap plans are not included in this annual open enrollment period.

Determining if traditional Medicare or a private Medicare Advantage plan is appropriate for someone is a highly individualized assessment. The framework in which the programs operate can provide a general foundation for making this decision. For example, Medicare Advantage plans are often viewed as simpler "one-stop shopping" because individuals are able to obtain Part A, Part B and Part D coverage in a single package. Additionally, Medicare Advantage plans are able to offer limited supplemental

[45] *But see*, Gretchen Jacobson, Tricia Neuman, & Anthony Damico, *Medicare Advantage Plan Switching: Exception or Norm?*, KFF (Sept. 2016) https://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-Plan-Switching-Exception-or-Norm, (finding that "[r]elatively few Medicare Advantage enrollees, roughly one in ten, voluntarily switch from one MA-PD to another MA-PD each year, suggesting that plan switching among seniors is more the exception than norm.").

benefits such as a fitness benefit or dental care.[46] However, plans can also charge additional premiums for such benefits, and the benefits themselves may be quite limited. For example, the dental benefits are often limited to cleanings, exams, fluoride treatments and x-rays, and do not cover more expensive procedures.[47]

Another advantage for individuals enrolled in Medicare Advantage plans is that since 2011, Medicare Advantage plans have

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[46] S*ee* Ctr. for Medicare Advocacy Issue Brief, "*New Medicare Advantage Supplemental Benefits: An Advocates' Guide to Navigating the New Landscape*" (Oct. 2019) https://www.medicareadvocacy.org/wp-content/uploads/2019/10/Fully-Informed-Advocates-Guide-to-MA-Supplemental-Benefits-2019.pdf (showing that beginning in 2019, Medicare Advantage plans have been able to offer additional supplemental benefits that were not offered in previous years); *See also*, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, *Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits*, KFF (June 21, 2021) https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/, (finding that "most enrollees in individual Medicare Advantage plans (those generally available to Medicare beneficiaries) are in plans that provide access to eye exams and/or glasses (99%), telehealth services (94%), dental care (94%), a fitness benefit (93%), and hearing aids (93%). Similarly, most enrollees in SNPs are in plans that provide access to these benefits.").

[47] Meredith Freed, Tricia Neuman & Gretchen Jacobson, *Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries*, KFF (Mar. 19, 2019), https://www.kff.org/medicare/issue-brief/drilling-down-on-dental-coverage-and-costs-for-medicare-beneficiaries/ (reporting that in 2016, 60% of Medicare Advantage enrollees, or about 10.2 million beneficiaries, had access to some dental coverage. The remaining 40% of all Medicare Advantage enrollees, or almost 7 million beneficiaries, did not have access to dental coverage under their plan. Some Medicare Advantage plans charge an additional premium for dental benefits, and enrollees must pay that premium in order to receive the dental coverage. Overall, almost three in ten (29%) Medicare Advantage enrollees with access to dental benefits under their plan may be required to pay a monthly premium, averaging $284 per year in 2016, for the plan dental benefits. Of the 7 million Medicare Advantage enrollees in plans that offered both preventive and more extensive dental benefits, about four in ten (43%) are in plans with dollar limits on coverage, and most plans had limits around $1,000. In addition to dollar limits, Medicare Advantage plans typically limit the number of services covered). *See also*, Meredith Freed et al., *Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage*, KFF (sept. 21, 2021), https://www.kff.org/medicare/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/.

been required to provide an annual out-of-pocket limit for services covered under Parts A and Parts B of Medicare.[48] This protection does not exist in traditional Medicare. In 2021, the out-of-pocket limit may not exceed $7,550 for in-network services and $11,300 for in-network and out-of-network services combined.[49] These limits apply only to services under Part A and Part B of Medicare, and do not apply to Part D.[50] Whether a plan has only an in-network cap or a cap for in-network and out-of-network services varies based on the type of plan.[51] According to Kaiser Family Foundation research, the weighted average out-of-pocket limits for Medicare Advantage enrollees for 2021 for PPOs, for in-network services was $5,091 and $9,208 for both in-network and out-of-network services.[52] While having a cap at any level is beneficial for beneficiaries, a cap that is so high does not alleviate the high costs of care stemming from an unexpected catastrophic medical issue, or for beneficiaries with high annual medical costs.

The main barrier to accessing care when enrolled in Medicare Advantage is the limited network of providers available to enrollees, and the higher costs associated with going outside of

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[48] 42 C.F.R. §§ 422.100 (2018); *See also* §§ 422.101 (2018) (stating that since 2011, local MA plans (and, since 2012, regional preferred provider plans, or PPOs) must establish a yearly maximum out-of-pocket (MOOP) liability amount for enrollees for all Part A and B services that does not exceed the maximum set yearly by CMS).

[49] Freed, Fuglesten Biniek, Damico & Neuman, *supra* note 46.

[50] The separate out-of-pocket threshold for Part D spending is $6,550 in 2021. It is significant to note there is still cost-sharing in Part D once the catastrophic level is reached as there is no hard cap in Part D. *See* Kaiser Family Foundation, *An Overview of the Medicare Part D Prescription Drug Benefit*, (Oct. 14, 2020), https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/.

[51] Freed, Fuglesten Biniek, Damico & Neuman, *supra* note 46.

[52] *Id.* (stating that premiums and other cost sharing is often difficult to compare from one MA plan to another, unlike Medigaps that have standard benefit packages).

the network.[53] By contrast, beneficiaries in traditional Medicare can see any Medicare participating provider,[54] and pay the standard Medicare cost-sharing rate. In most plans, a beneficiary is not able to go to any physician or hospital he or she may choose. While some plan types, such as PPOs, allow enrollees to go out-of-network, usually with higher cost-sharing, HMOs tend to employ limited networks (other than point of service, or POS plans). HMOs continue to enroll the most beneficiaries.[55] For the majority of MA enrollees in HMOs, there are no covered services outside of the network or service area.[56] Because beneficiaries are often limited to the plan's network of providers and facilities with whom they contract, if a beneficiary wishes to see a provider or go to a facility

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[53] *See*, General Accounting Office (GAO), *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy* (Aug. 2015), https://www.gao.gov/products/gao-15-710, (showing how the Centers for Medicare and Medicaid Services (CMS) ensures adequate access to care for Medicare Advantage (MA) enrollees. GAO recommended that "[t]he Administrator of CMS should augment oversight of MA networks to address provider availability, verify provider information submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters."); *See also*, Gretchen Jacobson et al., *Medicare Advantage Hospital Networks: How Much Do They Vary?* KFF (Jun. 20, 2016), https://www.kff.org/medicare/report/medicare-advantage-hospital-networks-how-much-do-they-vary/.

[54] *See* Nancy Ochieng, Karyn Schwartz & Tricia Neuman, *How Many Physicians Have Opted-Out of the Medicare Program?*, KFF (Oct. 22, 2020), https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/ (stating that currently, physicians and other health care providers may register with traditional Medicare under three options: 1) participating provider, 2) non-participating provider, or 3) an opt-out provider).

[55] *See*, MedPAC, "*The Medicare Advantage Program: Status Report, March 2021 Report to the Congress Medicare Payment Policy*", (Mar 2021), http://medpac.gov/docs/default-source/reports/mar21_medpac_report_ch12_sec.pdf?sfvrsn=0 (stating that according to the Medicare Payment Advisory Commission (MedPAC), as of July 2020, there were 15 million HMO enrollees (24% of all Medicare beneficiaries)).

[56] *See*, Medicare.gov, "*Doctors, providers & hospitals in Medicare Advantage Plans*," https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/doctors-providers-hospitals-in-medicare-advantage-plans (explaining the networks, with the exception of urgent or emergent services, though those are often defined in a very limited manner).

outside of the network, they typically pay higher cost-sharing when going outside the network, if they are even able to get coverage.[57] In addition, plans can terminate providers from their networks mid-year, while a beneficiary's corresponding rights to change plans mid-year are limited.[58]

Medicare Advantage plans also employ utilization management and cost containment tools, which often translate to obstacles to care for beneficiaries. For example, a plan can require a beneficiary to obtain prior authorization in order to see certain specialists, or before certain procedures. In contrast, prior authorizations are very limited in traditional Medicare, resulting in fewer barriers to necessary care in the traditional Medicare program. In 2021, 99% of Medicare Advantage enrollees were in plans that required prior authorization for some services.[59] Medicare Advantage plans usually utilize prior authorization requirements for more expensive services, like inpatient hospital or skilled nursing facility stays, or Part B drugs; prior authorization is not used frequently for preventive services.

A 2018 HHS Inspector General report examined whether MA plans were engaging in inappropriate denials of prior authorizations, because the rates of denials were so high.[60] The report found that when beneficiaries and providers appealed preauthorization and payment denials, MA plans "overturned 75% of their own denials."[61] At the same time, "beneficiaries and providers appealed

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[57] *Id*. (stating "In HMO Plans, you generally must get your care and services from providers in the plan's network, except: Emergency care; Out-of-area urgent care; Out-of-area dialysis").

[58] In an effort to strengthen MA enrollee consumer protections, in June 2014, Congresswoman Rosa DeLauro (D-CT) and Senator Sherrod Brown (D-OH) introduced the *Medicare Advantage Participant Bill of Rights Act of 2014* (H.R. 4998/S. 2552). Senator Richard Blumenthal (D-CT) is a strong advocate and co-sponsor of the bill. Among other things, this bill would prohibit MA plans from dropping providers during the middle of the plan year unless they can show cause. It would improve notice to plan enrollees about annual changes to provider networks *before* they commit to joining the plan.).

[59] Freed, Fuglesten Biniek, Damico & Neuman, *supra* note 46.

[60] *See* Department of Health and Human Services Office of Inspector General, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, OEI-09-16-00410 (Washington, D.C.: September 2018).

[61] *Id*.

only 1% of denials to the first level of appeal."[62] Such widespread use of prior authorization often leads to problems accessing care.

The OIG report analyzed that:

> [H]igh overturn rates when beneficiaries and providers appeal denials, and CMS audit findings about inappropriate denials, raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs [Medicare Advantage Organizations] are required to provide. These findings are particularly concerning because beneficiaries and providers rarely use the appeals process designed to ensure access to care and payment, and CMS has repeatedly cited MAOs for issuing incorrect or incomplete denials letters, which can impair a beneficiary's or provider's ability to mount a successful appeal.[63]

These findings demonstrate that prior authorization and other utilization management tools that serve as significant barriers to care are widespread in MA plans.

If care is needed outside of a Medicare Advantage plan's service area, the plan will generally only cover that care if it meets the plan's definition of emergency care, and the beneficiary must return to the service area for routine care. This is much more limited than traditional Medicare, which allows beneficiaries to see any Medicare participating provider throughout the U.S. Participating providers agree to traditional Medicare's fee schedule rates as full payment for their services, so that beneficiaries generally pay 20% as coinsurance. According to a 2020 Kaiser Family Foundation

[62] *Id.*
[63] *Id.*

report, almost all providers participate in Medicare.[64] The report found that "only 1% of non-pediatric physicians have formally opted-out of the Medicare program" in 2020, varying by specialty, with "little state-level variation in the percent of physicians opting-out, with only three states (Alaska, Colorado, Wyoming) having opt-out rates at or above 2% in 2020".[65]

For 2021, the average Medicare beneficiary had 33 Medicare Advantage plans available to them, 27 of which include prescription drug coverage (MA-PDs).[66] There are 3,550 MA plans nationwide available for individual beneficiary enrollment in 2021, representing a 13% increase from 2020.[67] Almost 90% of all MA plans include prescription drug coverage in 2021.[68] This is the largest number of plan options available to beneficiaries in the last decade.[69] There is wide variation in availability of plans by geographic area in the country, with some areas having 35 plan options, and others having two or fewer.[70] Cost-sharing in Medicare Advantage can vary by plan and by service.[71] Premiums in Medicare Advantage vary by plan.[72]

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[64] Ochieng, Schwartz & Neuman, *supra* note 54; *See also* Center on Budget and Policy Priorities (CBPP), "*Executive Order, Other Administration Actions Would Weaken Medicare*," (Nov. 7, 2019) https://www.cbpp.org/research/health/executive-order-other-administration-actions-would-weaken-medicare: (explaining that "almost all physicians and practitioners registered with Medicare (96% are participating providers. Participating providers accept Medicare's fee schedule rates as full payment for their services, and beneficiaries generally pay 20% of the scheduled amount as coinsurance. A few physicians (4%) are non-participating providers. Non-participating providers may charge 15% more than what Medicare pays, and beneficiaries are liable for that additional amount on top of the usual coinsurance. Very few physicians and dentists (0.7% of practitioners) opt out of Medicare. Opt-out providers may charge whatever they and their Medicare patients agree to through a private contract; Medicare pays nothing, and the patient must pay the entire amount.").

[65] *Id*.

[66] Jeannie Fuglesten Biniek et al., *Medicare Advantage 2021 Spotlight: First Look*, KFF (Oct. 2020), https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/.

[67] *Id.*

[68] *Id.*

[69] *Id.*

[70] *Id.*

[71] Freed, Fuglesten Biniek, Damico & Neuman, *supra* note 46.

[72] Fuglesten Biniek et al., *supra* note 66.

Equity Concerns in Medicare Advantage

Though deciding on a Medicare Advantage plan is a personal health decision, some general trends in Medicare Advantage enrollment, and disenrollment are informative, particularly the trends that highlight disparities in care based on health, age, and race. Some of those trends are particularly concerning for older and sicker Medicare beneficiaries. Research suggests that healthier and younger enrollees tend to have more favorable views of their Medicare Advantage plans than sicker and older enrollees. Some research has pointed to the payment structure in Medicare Advantage as favoring healthier and younger beneficiaries.[73] According to research compiled by the Centers for Medicare & Medicaid Services (CMS), quality performance is lower for Black beneficiaries than for White beneficiaries in Medicare Advantage.[74] Kaiser Family Foundation data demonstrate that Black beneficiaries in Medicare Advantage reported cost-related problems at a higher rate than in traditional Medicare; Black beneficiaries in traditional

[73] Momotazur Rahman, et al., *High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare*, Health Affairs (Oct. 2015) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676406/ (finding that

> [b]ecause Medicare Advantage plans receive prospective, capitated payments to finance and deliver services for their enrollees, they operate under strong incentives to manage their members' health care costs. Policy makers have been concerned that capitated payments give Medicare Advantage plans an incentive to enroll healthier beneficiaries and to avoid enrolling those with chronic conditions. Indeed, a large body of literature based on data from the 1990s and early 2000s found that Medicare Advantage plans disproportionately enrolled healthier beneficiaries. This phenomenon, known as favorable risk selection, has historically yielded substantial overpayments to Medicare Advantage plans.).

[74] Ctr. for Medicare & Medicaid Serv., (CMS), "Racial, ethnic, and gender disparities in health care in Medicare Advantage," (Apr. 2021), https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf.

Medicare who had supplemental insurance had even lower rates of cost-related problems.[75] According to Kaiser Family Foundation, "[h]alf of Black Medicare Advantage enrollees in fair or poor self-assessed health reported cost-related problems, compared to one-third of Black beneficiaries in traditional Medicare overall and just over one-fourth of Black beneficiaries in traditional Medicare with supplemental coverage."[76]

The differences were even more striking among Black Medicare beneficiaries who are under age 65 with disabilities. Kaiser Family Foundation found that about half (49%) of those enrolled in Medicare Advantage reported a cost-related problem, which is almost twice the rate reported among those with traditional Medicare overall (26%), and significantly higher than the rate of cost-related problems reported among beneficiaries in traditional Medicare who also had supplemental coverage (19%).[77]

Though this paper does not focus on Medicare Advantage payment, a recent study is illustrative of the racial inequities in quality of care that can result from Medicare Advantage payment

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[75] Jeannie Fuglesten Biniek et. al, *Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, KFF (June 25, 2021), 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/?utm_campaign=KFF-2021-Medicare&utm_medium=email&_hsmi=136245934&_hsenc=p2ANqtz--K3-McLM7FJKUQcUIMXntOZUgey_QlmT7VC2qrLku5wJbRUyadXPiZekbW7qx7uC_YojxQTwHgFZ27P0skPLGxaekmkg&utm_content=136245934&utm_source=hs_email (finding that a smaller share of Black beneficiaries in traditional Medicare (24%) than in Medicare Advantage (32%) reported cost-related problems. Rates of cost-related problems were lower among Black beneficiaries in traditional Medicare with Medicaid and other forms of supplemental insurance (20%)).

[76] *Id.*

[77] Jeannie Fuglesten Biniek, et al., *Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage*, KFF (Jun 25, 2021), 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/?utm_campaign=KFF-2021-Medicare&utm_medium=email&_hsmi=136245934&_hsenc=p2ANqtz-_mOX_OKL4NKfeZ1AWqER-Zx-tb7mANv9UxfUAx7DM2z23-eN8t3E5Ogk3WGM3Rb0JQ4M57bDemXcT3z5CZLrtJ0ZkYuA&utm_content=136245934&utm_source=hs_email.

incentives. The research published in September 2021 in Health Affairs, "Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements," found that double bonuses[78] for Medicare Advantage plans are "not an efficient. . . mechanism for improving the MA program. . . nor are they equitable in allocation of those dollars, disproportionally benefiting White beneficiaries relative to Black beneficiaries," without improving quality or enrollment in the MA program.[79]

The study found that "Black beneficiaries were substantially less likely to reside in counties offered double bonuses than White beneficiaries, thus contributing to racial disparities in the allocation of double bonus dollars," disfavoring Black beneficiaries.[80] CMS structures the system with the expectation that quality bonus payments will partially be passed on to beneficiaries through assistance with Medicare premiums or additional benefits like dental benefits for example. Therefore, differences in the allocation of Medicare Advantage bonus payments to counties that are eligible

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[78] Adam A. Markovitz et al., *Medicare Advantage Plan Double Bonuses Drive Racial Disparity In Payments, Yield No Quality Or Enrollment Improvements*, Health Affairs (Sept. 2021), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00349 (showing that the Health Affairs study describes double bonuses as follows:

> An unusual feature of the MA bonus program is the delineation of "double-bonus" counties. In these counties higher-quality plans receive certain MA bonuses at double the dollar level paid to comparably performing plans in counties that are ineligible for double bonuses. Through the ACA, Congress created three criteria that a county must meet to be eligible for double bonuses: historically high MA enrollment (at least 25% in 2009); low Medicare fee-for-service spending (below the national average in a given year); and a 2004 "urban floor" designation, given to Metropolitan Statistical Areas (MSAs) with at least 250,000 residents that qualify for the minimum MA benchmark rate and granted to areas with low fee-for-service spending. Although the proportion of counties qualifying for double-bonus status is small, at around 7% of counties nationally, the impact of their double bonus status is large because 27% of MA beneficiaries live in them, based on our analysis of Medicare data.).

[79] *Id.*

[80] *Id.*

and not eligible for double bonuses could result in racial and geographic disparities. These could include differences in availability of enhanced benefits, or "translate to higher premiums for the same benefits when offered to primarily Black versus primarily White populations, which could harm the financial well-being of Black beneficiaries."[81] These findings, taken together with the Kaiser Family Foundation report revealing that Black beneficiaries had more cost-related problems in Medicare Advantage is concerning. According to Kaiser Family Foundation, "enrollees in Medicare Advantage do not generally receive greater protection against cost-related problems than beneficiaries in traditional Medicare with supplemental coverage, particularly for some enrollees, such as Black beneficiaries in relatively poor health, despite having an out-of-pocket cap and additional benefits."[82] These disparities are particularly significant given that half of all Black and Hispanic beneficiaries were enrolled in a Medicare Advantage plan, compared to 36% of White beneficiaries in 2018.[83]

Research also indicates that sicker beneficiaries are not as well served by Medicare Advantage. A 2021 Government Accountability Office (GAO) report, "Beneficiary Disenrollments to Fee for Service in Last Year of Life Increase Medicare Spending," looked for increases in spending in the traditional Medicare program due to beneficiaries disenrolling from Medicare Advantage in the last year of life.[84] Though the report was aimed at investigating costs for the traditional Medicare program, totaling nearly half a billion dollars annually for the years of the study, the underlying data is useful for the Medigap discussion. The report found that beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate of all other Medicare Advantage beneficiaries, with certain Medicare Advantage Organizations (MAOs), which may offer several plans, experiencing disenrollment at the rate of nearly

[81] *Id.*

[82] Nancy Ochieng et al., *Racial and Ethnic Health Inequities and Medicare*, KFF (Feb. 16, 2021) https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-sources-of-coverage/.

[83] *Id.*

[84] Beneficiary Disenrollments to Fee- for Service in Last Year of Life Increase Medicare Spending, 21 GAO 482 (2021).

10 times higher for beneficiaries in the last year of life than all other beneficiaries.[85] As beneficiaries in the last year of life are generally recognized to be high-cost and disproportionately requiring specialized care, the findings underscore that the cost containment measures employed by Medicare Advantage plans appear to limit access to necessary care for sick beneficiaries. "While disenrollment among some beneficiaries is expected, high levels of disenrollment, or disparities in disenrollment among beneficiaries in poorer health, may indicate potential issues with beneficiary access to care or with the quality of care provided."[86]

The GAO report also cited that a "number of other studies have found that beneficiaries in poorer health may be more likely to disenroll from MA to join FFS [Fee-for-Service, i.e., traditional Medicare]."[87] While the GAO report notes limited CMS review of the reasons behind Medicare Advantage disenrollment in the final year of life, and focuses its recommendations on the increased (substantial) costs to the traditional Medicare program to manage these high cost patients, these important policy issues are not the focus of this paper. However, the underlying data from the report supports this paper's claim that there are equity concerns regarding the care that Medicare Advantage plans provide to sicker and older beneficiaries.

There has been much research highlighting the fact that Medicare Advantage enrollees who experience adverse health

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[85] *Id.* at 12. Report finding that

> Certain MAOs—which may offer multiple MA plans—had substantially higher relative increases in disenrollments to join FFS by beneficiaries in the last year of life compared to other MAOs. For example, in 2017, the MAO with the highest relative increase in disenrollments to join FFS saw beneficiaries in the last year of life disenroll at nearly 10 times the rate of all other beneficiaries. . . . In both 2016 and 2017, the same two MAOs had the highest relative increase in disenrollments by beneficiaries in the last year of life.

[86] *Id*.

[87] *Id*.

events or who have greater health needs switch from Medicare Advantage into traditional Medicare at higher rates.[88]

A 2015 study in Health Affairs, "High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare," found increased rates of switching out of Medicare Advantage into traditional Medicare among people who used home health and nursing home services, when compared to beneficiaries who did not use home health and nursing home care. Conversely, the study found lower rates of switching out of traditional Medicare into Medicare Advantage among people who used nursing home, home health, or acute inpatient care, when

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[88] *See* David J. Meyers, et al., *Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries*, JAMA Intern Med (Feb. 25, 2019), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725083 (finding "[r]esults of this study suggest that substantially higher disenrollment from MA plans occurs among high-need and Medicare-Medicaid eligible enrollees. This study's findings suggest that star ratings have the strongest association with disenrollment trends, whereas increases in monthly premiums are associated with greater likelihood of switching plans."); *See also* Qijuan Li, et al., *Medicare Advantage Ratings And Voluntary Disenrollment Among Patients With End-Stage Renal Disease*, Health Affairs (January 2018), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0974 (finding that there is "a strong association between MA plans' star ratings and incident ESRD patients' voluntary disenrollment from MA plans to traditional Medicare in the year following the initiation of dialysis. These patients' disenrollment rates, especially rates of switching from MA to traditional Medicare, were significantly higher than disenrollment rates among all MA beneficiaries. These findings suggest that the rate of voluntary disenrollment among high-cost, high-need patients may be an important measure of MA plan quality, that CMS and other policy stakeholders may want to monitor such disenrollment rates, and that low plan quality may lead to increased spending in traditional Medicare by shifting the costs of the ESRD population from some MA plans to traditional Medicare. Further research is needed to understand whether these findings extend to other chronically ill populations."); Sungchul Park, David J. Meyers & Brent A. Langellier, *Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare,* Health Affairs (March 2021) https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01435(even greater among rural enrollees who were high cost or high need); *See also*, Patricia Neuman & Gretchen Jacobson, *Medicare Advantage Checkup*, New England Journal of Medicine (Nov. 29, 2018) https://www.nejm.org/doi/full/10.1056/nejmhpr1804089 (finding evidence that quality of care is mixed with 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.").

compared to beneficiaries who did not use these services. [89] "We found that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (3% versus 7%), short-term nursing home care (9% versus 4%), and home health care (8% versus 3%). These results were magnified among people who were enrolled in both Medicare and Medicaid."[90]

In its conclusion, the Health Affairs study summarized its findings of:

> substantial switching from Medicare Advantage to traditional Medicare by beneficiaries who used nursing home and home health care, particularly those who were also eligible for Medicaid, and virtually no entry into Medicare Advantage plans by traditional Medicare beneficiaries who used these services or acquired dual eligibility. We found that a high proportion of beneficiaries with nursing home or home health care use choose to exit the Medicare Advantage program by the start of the next plan year. Thus, our study raises questions about the role of Medicare Advantage plans in serving high-cost patients with complex health care needs that span acute, post-acute, and long-term care settings." The report concluded that "substantial switching from Medicare Advantage to traditional Medicare by beneficiaries who used nursing home and home health care, particularly those who were also eligible for Medicaid, and virtually no entry into Medicare Advantage plans by traditional Medicare beneficiaries who used these services or acquired dual eligibility. We found that a high proportion of beneficiaries with nursing home or home health care use choose to exit the

[89] Rahman, et al., *supra* note 73.
[90] *Id*.

> Medicare Advantage program by the start of the next plan year. Thus, our study raises questions about the role of Medicare Advantage plans in serving high-cost patients with complex health care needs that span acute, postacute, and long-term care settings.[91]

Taken together, the above data underscore health equity concerns with Medicare Advantage. The increased enrollment in Medicare Advantage (Medicare Advantage enrollees now account for more than four in 10 beneficiaries overall)[92] not only raises access issues for beneficiaries enrolled in the plans, but also undermines the social insurance structure central to the Medicare program. With legislative and administrative action over many years, the steady increase in measures that disproportionately favor the private Medicare Advantage program over traditional Medicare has led to increased enrollment in the plans and concerns about the traditional Medicare program being chipped away and slowly becoming privatized.[93] It is vital to the very existence of the Medicare program

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[91] *Id*.

[92] Koma, Cubanski & Neuman, *supra* note 20, (finding, "In 2018, Medicare Advantage covered about 4 in 10 Medicare beneficiaries (39%), or 21 million people with Medicare. (Based on more current enrollment data, the total number of Medicare Advantage enrollees increased to 24 million in 2020, but the MCBS, which we use here for demographic analysis of coverage sources, is not available beyond 2018.").

[93] *See,* Center for Medicare Advocacy, *Tipping the Scales Toward Medicare Advantage*, (Mar. 21, 2018), https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/; *See also*, David A Lipschutz, *Commentary: Don't Further Privatize Medicare*, Inquiry (Aug 5, 2019), See also, Emily Gee, Maura Calsyn & Nicole Rapfogel, *Trump's Plan To Privatize Medicare*, Center for American Progress (CAP), (Oct. 11, 2019) https://www.americanprogress.org/issues/healthcare/news/2019/10/11/475646/trumps-plan-privatize-medicare/; *See also* The New York Times, *Medicare's Private Option Is Gaining Popularity, and Critics,* (Feb. 21, 2020) https://www.nytimes.com/2020/02/21/business/medicare-advantage-retirement.html**;** *See also* Bob Herman, *Medicare has become more of a private marketplace — and it's costly*, Axios, (Aug 11, 2021) https://www.axios.com/medicare-advantage-enrollment-spending-pandemic-risk-adjustment-d1a608ff-15eb-47bf-8952-0e1c5af097d5.html; *See also*, Trudy Lieberman, *This latest under-the-radar program could push Medicare deeper into private hands*, USC Annenberg, Center for Health Journalism, (Mar. 11, 2021) https://centerforhealthjournalism.org/2021/03/10/latest-under-radar-program-could-push-medicare-deeper-private-hands; *See also*, Center for Medicare Advocacy, *MEDICARE &*

that it maintain a social insurance structure, providing reliable, consistent access to care on which all beneficiaries can rely, with a defined benefit and guaranteed coverage regardless of health status, age or income.

This paper examines the equity concerns in Medicare Advantage in order to illustrate the possible perils associated with beneficiaries being unable to exit a Medicare Advantage plan without extreme financial consequences of being exposed to out-of-pocket costs in traditional Medicare without supplemental insurance. While this paper does not address policy proposals aimed at improving Medicare Advantage oversight, payment reform or legislation to achieve parity between Medicare Advantage and traditional Medicare, the clear health equity concerns in Medicare Advantage call out for many policy changes.[94]Addressing the equity concerns in Medicare Advantage would help to address the underlying disparities central to the decision to switch from Medicare Advantage to traditional Medicare.

Medigap Consumer Protections Lacking in Most States for Beneficiaries over 65

YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage, (Sept. 20, 2021*)* https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid={{ContactsEmailID.

[94]See Committee for a Responsible Federal Budget, *Reducing Medicare Advantage Overpayments*, (Feb. 23, 2021), https://www.crfb.org/papers/reducing-medicare-advantage-overpayments; See also Center on Budget and Policy Priorities, *Medicare Advantage Upcoding, Overpayments Require Attention*, (Oct. 30, 2018) https://www.cbpp.org/blog/medicare-advantage-upcoding-overpayments-require-attention; *June 2021 Report to Congress*, (Jun 2021), MedPAC, http://medpac.gov/docs/default-source/reports/jun21_executivesummary_medpac_report_to_congress_sec.pdf?sfvrsn=0.

For beneficiaries ages 65 and older, there are federal guaranteed issue protections for Medigap policies during the six-month Medigap open enrollment period when enrolling in Medicare Part B, as well as in the event of limited, specific qualifying circumstances.[95] Guaranteed issue protections prohibit insurers from denying a Medigap policy to eligible applicants, including people with pre-existing conditions. There are also federal guaranteed issue protections during "trial" periods for Medicare Advantage plans, including during the first year older adults enroll in Medicare.[96] This allows older adults who disenroll from a Medicare Advantage plan within the first year to have guaranteed issue rights to purchase a Medigap policy when they switch to traditional Medicare. Another trial period allows Medicare beneficiaries to cancel their Medigap policy and enroll in a Medicare Advantage plan; these beneficiaries have guaranteed issue protections that allow them to reenroll in the same Medigap policy if, within a year of enrolling in a Medicare Advantage plan, they disenroll from Medicare Advantage and switch to traditional Medicare.[97] Other than a few very specific and limited circumstances, after the initial six months of enrolling in Medicare Part B, or the first year trial in Medicare Advantage, older adults generally do not have federal guaranteed issue protections when applying for a Medigap plan.

Though states have the flexibility to adopt Medigap consumer protections that are more generous than the minimum federal requirements, most states do not exercise this flexibility.[98] Almost all states allow insurance companies to deny Medigap insurance policies to older adults after their initial enrollment in Medicare because of a pre-existing medical condition, with limited

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[95] Guaranteed Issue Rights, Medicare.gov, https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap/guaranteed-issue-rights.
[96] 42 U.S.C. § 1395ss(s).
[97] If that former policy is not available, beneficiaries can purchase another Medigap plan.
[98] Boccuti, Cristina et al., *Medigap Enrollment and Consumer Protection Vary Across States,* KFF (Jul. 11, 2018), https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/.

exceptions.[99] States also have the flexibility to develop rules on whether Medigap premiums may be impacted by factors like a policyholder's age. These factors can be considered even during guaranteed issue open enrollment periods. The three different rating systems states can permit or require Medigap insurers to utilize in developing premiums are community rating, issue-age rating, or attained-age rating. Community rating does not allow premiums to be based on the applicant or policyholder's age or health status, thereby providing the strongest consumer protection.[100] Attained age rating allows premiums to increase as beneficiaries age; these are often set at attractive lower rates for younger beneficiaries and can increase at unpredictable rates.

Only eight states (Arkansas, Connecticut, Massachusetts, Maine, Minnesota, New York, Vermont and Washington) require community rating, meaning all Medigap enrollees are charged the same premium regardless of disease.[101] Only four states (Connecticut, Maine, Massachusetts, and New York) require guaranteed issue, meaning that Medigap insurers must issue policies on demand.[102] Those four states require that Medigap plans be available to all Medicare beneficiaries ages 65 and older either continuously throughout the year or at least one time per year.[103] In all other states and the District of Columbia, insurers may deny a Medigap policy to older adults, except during their initial open enrollment period when they start on Medicare, or when applicants

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[99] *Id.*

[100] *Id.* Insurers in states that require community rating may charge different premiums based on other factors, such as smoking status and residential area.

[101] *Id*.

[102] *Id.* "Consistent with federal law, Medigap insurers in New York, Connecticut, and Maine may impose up to a six-month "waiting period" to cover services related to pre-existing conditions if the applicant did not have six months of continuous creditable coverage prior to purchasing a policy during the initial Medigap open enrollment period. Massachusetts prohibits pre-existing condition waiting periods for its Medicare supplement policies."

[103] *Id*.

have other specified qualifying events, such as the loss of retiree health coverage.[104] Depending on their state, Medicare beneficiaries who miss these limited periods of enrollment may unintentionally forgo the opportunity to purchase a Medigap policy if they decide they need one, or if they choose to switch to traditional Medicare after being in a Medicare Advantage plan for a couple of years.[105]

The lack of federal consumer protections for guaranteed issue results in serious financial consequences. Aside from the four states with guaranteed issue protections, most Medicare beneficiaries over 65 who are in traditional Medicare and miss this initial open enrollment period, would be subject to medical underwriting, which could result in being denied a Medigap policy due to pre-existing conditions.[106]

This is a particularly significant barrier for Medicare beneficiaries over 65 who enroll in a private Medicare Advantage plan during their initial enrollment period, then decide to switch to traditional Medicare after the one-year trial period. As discussed previously, sicker and older beneficiaries switch from Medicare Advantage to traditional Medicare at higher rates than younger and healthier enrollees. So, it is precisely the group of individuals who are more likely to utilize health care services, and would need Medigap protections for out-of-pocket costs, who may be denied coverage.

Layered on top of the serious financial consequences of not having access to Medigap plans or having extremely costly premiums for plans, is the concern that the barriers to Medigap access deter beneficiaries from switching to traditional Medicare, or

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[104] See 42 U.S.C. § 1395ss(s)(3) (listing the various circumstances).

[105] *See* Kaiser Family Foundation (KFF), *Traditional Medicare…Disadvantaged?*, (Mar. 31, 2016), https://www.kff.org/medicare/perspective/traditional-medicare-disadvantaged/; *see also* Boccuti, Cristina et al., *Medigap Enrollment and Consumer Protection Vary Across States,* KFF (Jul. 11, 2018), https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/; *See also*, The New York Times, *Medicare's Private Option Is Gaining Popularity, and Critics,* (Feb. 21, 2020),https://www.nytimes.com/2020/02/21/business/medicare-advantage-retirement.html.

[106] Boccuti, Cristina et al., *Medigap Enrollment and Consumer Protection Vary Across States,* KFF (Jul. 11, 2018), https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/.

lead them to re-enroll in Medicare Advantage. A 2019 study conducted at Brown University School of Public Health, published in Health Affairs, "Limited Medigap Consumer Protections Are Associated With Higher Reenrollment In Medicare Advantage Plans," highlighted this phenomenon. The study found that "in states without consumer protections in the Medigap market, high-need MA enrollees had a 16.9-percentage-point higher reenrollment rate in MA after switching from it to traditional Medicare, compared to high-need enrollees in states with guaranteed issue and community rating for Medigap. Policy makers should consider consumer protections in the Medigap market that ensure adequate access to coverage for high-need Medicare beneficiaries." [107] The study's authors also noted that

> "Medicare beneficiaries with complex care needs often face a higher burden of costs and may benefit from a greater continuity of care. In most states these enrollees may face significant barriers to enrollment in Medigap that may increase their exposure to high out-of-pocket spending and lead to disruptions in the continuity of care if they need to switch between MA and traditional Medicare." [108]

The study identified an association between Medigap consumer protections that require guaranteed issue, and rates of remaining in traditional Medicare after switching from Medicare Advantage.[109] The study provides strong evidence to demonstrate the harm to beneficiaries who attempt to exit Medicare Advantage in order to enroll in traditional Medicare, only to find that they are unable to obtain supplemental insurance to assist with out-of-pocket costs in

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[107] *Id.*

[108] David J. Meyers, Amal N. Trivedi & Vincent Mor , *Limited Medigap Consumer Protections Are Associated with Higher Reenrollment In Medicare Advantage Plans*, Health Affairs, (May 2019) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6541000/pdf/nihms-1031031.pdf.

[109] *Id*.

traditional Medicare. In almost all states, these individuals are faced with two suboptimal choices: 1) either reenroll in Medicare Advantage—either their previous plan that they determined was not meeting their needs, perhaps due to the limited networks and utilization management that places barriers to care and increases their out-of-pocket spending—or another Medicare Advantage plan in their area, which may also have these limitations, or 2) face exposure to high out-of-pocket costs in traditional Medicare without the buffer of supplemental insurance to protect them from some of those costs.

Medigap Consumer Protections Lacking in Most States for Beneficiaries under 65

Federal consumer protections for Medigap policies do not apply to beneficiaries under age 65.[110] Medigap insurers are not required to sell Medigap policies to the over nine million Medicare beneficiaries under the age of 65, who qualify for Medicare based on their long-term disability. Insurance companies are not required to guarantee issuance of policies to these beneficiaries and therefore can freely deny coverage due to age, sex, and health status.[111]

However, many states have elected to voluntarily extend protections to their under-65 population. Currently, 34 states grant some degree of protection to disabled and end-stage renal disease (ESRD) Medicare beneficiaries.[112] Of the 34 states, some choose to extend the protections only to those with a disability, while some extend it only to those with ESRD. In the 16 states without state-protections, some insurers still voluntarily offer Medigap policies to those with disabilities and ESRD. However, given the health

[110] 42 U.S.C. §1395ss(s)(2).
[111] *Id*.
[112] Ctr. for Medicare & Medicaid Serv., (CMS), *2021: A Guide to Choosing a Medigap Policy* (2021), https://www.medicare.gov/media/9486, 40, which includes 33 states. Virginia is the 34th state, beginning January 2021; see, State Corporation Commission, *Additional Health Insurance Coverage Options for Medicare-Eligible Virginians Under Age 65*, https://www.scc.virginia.gov/newsreleases/release/Additional-Coverage-Options-Coming-for-Medicare-El.

conditions of this population, insurers can often charge much higher premiums based on their health status.

A Kaiser Family Foundation Report, "The Gap in Medigap"[113] provides historical context for the limitations on consumer protections for the under 65 Medicare population. The report details how the 1990 federal law created a gap in Medigap for beneficiaries under 65 with disabilities because insurers were opposed to the idea of providing an open enrollment period with guaranteed-issue rights to those under 65 on Medicare since many Medigap policies then covered some prescription drug costs. Insurers were concerned that higher drug spending among Medicare beneficiaries under 65, when compared to the over 65 population,[114] would drive up insurers' costs, resulting in higher premiums.

The report outlines how this reasoning is now moot because Medigap policies sold today are prohibited from covering prescription drug costs since Medicare Part D (established in 2006)[115] provides prescription drug coverage. Because Medigap insurers are no longer responsible for drug costs, and Medicare per capita costs are similar for younger beneficiaries with disabilities and the over 65 Medicare population, when Part D spending is excluded, the previous reasoning no longer holds true. The Kaiser Family Foundation report concludes by explaining that because of this change, federal consumer protections for this population are necessary.

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[113] Tricia Neuman & Juliette Cubanski, *The Gap in Medigap*, KFF, (Sept. 27, 2016) https://www.kff.org/medicare/perspective/the-gap-in-medigap/.

[114] Data supports the premise that the under 65 population had higher drug costs than the over 65 population: Juliette Cubanski**,** Tricia Neuman & Anthony Damico, *Similar but Not the Same: How Medicare Per Capita Spending Compares for Younger and Older Beneficiaries*, KFF (Aug. 16, 2016)https://www.kff.org/medicare/issue-brief/similar-but-not-the-same-how-medicare-per-capita-spending-compares-for-younger-and-older-beneficiaries/.

[115] *Id*. Beginning in 2006, with the start of the Medicare Part D prescription drug benefit.

> "In light of these data, it's not clear what the justification is for treating younger adults with disabilities differently from older adults when it comes to buying a Medigap policy. Revising federal law related to Medigap open enrollment rights and protections could help to reduce the gap in Medigap coverage between younger and older beneficiaries, help alleviate cost-related access problems among the relatively small but vulnerable group of people under 65 who qualify for Medicare, and provide more equitable treatment to Medicare beneficiaries across the states."[116]

When these beneficiaries turn age 65, federal law requires that they be eligible for the same six-month open enrollment period for Medigap that is available to new beneficiaries age 65 and older. The limits for those under 65 appear completely arbitrary, as the rest of the Medicare program functions identically for the under 65 population as it does for the over 65 population.[117]

Considerations for Expanding Medigap Federal Consumer Protections

Consumer protections that would promote health equity include making Medigap available to all individuals in traditional Medicare regardless of preexisting condition or age and setting premiums at the same rate for all beneficiaries, thereby improving access to the under 65 population. Expanded enrollment opportunities, like an annual enrollment period similar to the one for Medicare Advantage, or continuous enrollment, should also be explored on the federal level.

Legislation has been introduced in Congress that could address many of these shortcomings in consumer protections. The Elijah E.

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[116] Neuman & Cubanski, *supra* note 113.

[117] With the exception of Medicare Secondary Payer rules and size of employer. See, Ctr. for Medicare & Medicaid Serv., (CMS), Medicare Secondary Payer, (Jun. 30, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

Cummings Lower Drug Costs Now Act, (H.R. 3) passed in the House in the 116th session (2019-2021), though it was not taken up by the Senate at the time.[118] The Elijah E. Cummings Lower Drug Costs Now Act would have made progress in reducing the imbalance in enrollment rights between Medicare Advantage plans and Medigap plans by expanding federal Medigap protections to create guaranteed issue rights with respect to Medigap policies to all beneficiaries, thereby removing the exclusion for the under 65 Medicare population.[119] It also provided an additional one-time six month enrollment period for Medigap policies for individuals with Medicare Parts A and B who otherwise would not qualify for guaranteed issue of Medigap policies.[120] The bill also provided a one-time ability to pick up a Medigap policy after disenrolling from a Medicare Advantage plan (after the current one-year trial period right).[121] The Congressional Budget Office (CBO), which together with the staff of the Joint Committee on Taxation (JCT) estimates the costs of bills and resolutions, scored this legislation in 2019.[122] The scoring estimated the cost of the guaranteed issue provision for certain Medicare supplemental insurance policies at $14 billion.[123] While CBO's analysis did not detail the reasoning for this estimated cost to the Medicare program, it may have factored in an expectation that beneficiaries will utilize more services if they have improved access to supplemental insurance, which would better protect, or completely insulate them from out-of-pocket costs. While that might

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[118] While H.R. 3 was reintroduced in the 117th session, this version did not include the Medigap changes. *See*, Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, 117th Cong. (2021).
[119] Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, 116th Cong. § 801 (2019).
[120] *Id.* at § 801 (a)(2)
[121] *Id.* § 801 (b)
[122] CONG. BUDGET OFFICE, 116TH CONG., BUDGETARY EFFECTS OF H.R. 3, THE ELIJAH E. CUMMINGS LOWER DRUG COSTS NOW ACT 1 (Dec. 10, 2019) https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf.
[123] *Id.* at 5.

increase costs for the Medicare program, it does not mean that the care would not be necessary; it might suggest that beneficiaries currently forgo necessary care out of cost concerns if they do not have supplemental insurance. It is also possible that the estimate anticipated that more beneficiaries who wish to exit their Medicare Advantage plan will be able to join traditional Medicare if they have a new opportunity to access supplemental insurance because of this legislation. Since much research on this topic demonstrates that sicker enrollees are more likely to disenroll from Medicare Advantage, then those additional sicker beneficiaries joining traditional Medicare will tend to be costlier beneficiaries, making it reasonable to expect increases in spending for the traditional Medicare program. Though the CBO score suggests increasing cost to Medicare, it does not express an estimate of the impact on beneficiary Medigap premiums. It is certainly reasonable to expect some increase in premiums for beneficiaries if sicker beneficiaries are given an opportunity to enroll in a Medigap plan that they currently cannot access. There is a lack of comprehensive data or analysis exploring what percentage increase there would be, or the best mechanism to mitigate those possible increases. While improved access to a Medigap plan would certainly improve the financial stability of beneficiaries who are currently unable to obtain supplemental coverage, the impact on all premiums is also an important consideration that would need to be examined and studied when addressing proposals to expand access.

Texas Congressman Lloyd Doggett also sponsored legislation addressing Medigap consumer protections.[124] Rep. Doggett introduced the Close the Medigap Act into Congress in 2021.[125] The legislation makes several changes to the Social Security Act to expand beneficiary access to Medigap plans. The changes include prohibitions on Medigap insurers from denying issuance of coverage or basing policy prices, including premiums, on health status or medical condition.[126] Additionally, the legislation prohibits

[124] Previously introduced by other members of Congress in previous sessions of Congress.
[125] Close the Medigap Act of 2021, H.R. 4640, 117th Cong. (2021).
[126] *Id*. at § 2.

excluding benefits based on preexisting conditions. [127] The legislation also reverses the changes brought about in MACRA, by restoring access to the first dollar coverage through the two most popular Medigap policies (Plans C and F), which were eliminated for new beneficiaries starting January 1, 2020.[128]

The plans MACRA eliminated as an option for new beneficiaries pay benefits for the Part B deductible[129], which is $233[130] in 2022. Given their comprehensive first-dollar coverage, the plans are the most popular among enrollees, with over half of Medigap policyholders in one of these two plans.[131] Despite their popularity, Congress eliminated the plans, for new beneficiaries, out of concerns for cost and as a means of curbing utilization under the theory of "skin in the game."[132] The foundation of the argument being that if all costs are covered for beneficiaries and they have no cost-sharing, beneficiaries will have high utilization of medical services, including high cost, low value care. Further, that if beneficiaries are responsible for cost-sharing (i.e. they have "skin in the game"), they will reduce their utilization of low value, high cost services.[133] However, much research indicates that with increased

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[127] *Id* at § 2.
[128] *Id.* at § 6.
[129] Bonnie Burns, *2020 Changes to Medicare Medigap Supplement Insurance*, CALIFORNIA BROKER (Oct. 1, 2019), https://www.calbrokermag.com/in-this-issue/2020-changes-to-medicare-medigap-supplement-insurance/.
[130] Ctr. For Medicare & Medicaid Serv., (CMS) *Part B Costs*, MEDICARE.GOV (2022), https://www.medicare.gov/your-medicare-costs/part-b-costs.
[131] Bob Herman, *Changes Loom As Most-Popular Medigap Plans Face Extinction*, MODERN HEALTHCARE (June 25, 2016), http://www.modernhealthcare.com/article/20160625/MAGAZINE/306259966.
[132] Richard Stefanacci & Barney Spivack, *Medicare's Push for More "Skin in the Game,"* ANNALS OF LONG-TERM CARE (June 2012), https://www.hmpgloballearningnetwork.com/site/altc/article/medicare-s-push-more-skin-game.
[133] Medicare Payment Advisory Comm'n (MedPAC), *Report to the Congress*, P.L. 105-33 at 20 (March 15, 2021), https://www.medpac.gov/wpcontent/uploads/import_data/scrape_files/docs/defaultsource/reports/mar21_medpac_report_to_the_congress_sec.pdf., finding "Medicare uses beneficiary cost sharing, in part, to deter overuse of services."

cost-sharing, utilization decreases across the board, including high value services, as beneficiaries broadly forgo care because of the costs. This is especially apparent among older, chronically ill, and low-income beneficiaries.[134] These plans, known as the "Cadillac" policies of the supplement market, were feared to fuel the overutilization of medical services. However, this concern does not comport with the actual structure of Medigap policies as supplemental insurance. Because Medigap plans can only cover the cost-sharing for services that are already covered by Medicare, they are not a driver of unnecessary care. This theory of "skin in the game" is misapplied to this type of insurance. As noted by NAIC in a letter to HHS Secretary Kathleen Sebelius, in 2012, "Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services."[135] Medigap plans have no role in medical decisions.

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[134] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First-Dollar Coverage and Cost Shares Discussion Paper," October 31, 2011:

> Multiple studies have called into question the impact of increased cost sharing on the health outcomes associated with vulnerable populations (i.e., the elderly, chronically ill and low-income). Some suggest that increasing cost sharing for elderly patients may have adverse health consequences and may also increase total spending on health care. For example, a study published in the New England Journal of Medicine in January 2010 noted that increased cost sharing for ambulatory care for elderly patients led to both reduced outpatient visits and higher rates of hospital admission and inpatient days, as well as a higher percentage of enrollees who were hospitalized. The offsetting increase in hospitalization occurred particularly for those with lower incomes and those with chronic conditions. A Robert Wood Johnson Foundation report released in December 2010 similarly found that cost sharing increases were associated with adverse outcomes for vulnerable populations. It found that elderly, chronically ill and low-income patients had increased expenditures for emergency room visits and hospitalizations when cost sharing for prescription drugs was increased.

[135] Letter from NAIC & to Hon. Kathleen Sebelius, U.S. Dept. of Human and Health Serv., Secretary (Dec. 12, 2019), on file with author.

MACRA's changes are likely to change Medigap buying behaviors, perhaps pushing more beneficiaries into Medicare Advantage plans. The changes only began in 2020, so there has not been extensive data, or comprehensive research or analysis on the impacts yet, but it is an area that should be studied to determine the broader impacts on behavior.[136] Reversing these changes, as the Close the Medigap Act would do, is broadly supported by beneficiaries, experts on Medigap insurance, as well as Medicare beneficiary advocacy groups.[137]

Doggett's Close the Medigap Act also expands enrollment periods for plans by prohibiting waiting periods, elimination periods, look-back periods for preexisting conditions, and limits to periods of enrollment.[138] By expanding enrollment to allow Medicare beneficiaries with pre-existing conditions to purchase a Medigap policy at any time without being denied coverage or subjected to higher premiums, the legislation would bring the Medigap market in line with the rest of insurance industry post

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[136] *See* Gretchen Jacobson, Tricia Neuman & Anthony Damico, *Medigap Enrollment Among New Medicare Beneficiaries: How Many 65-Year Olds Enroll In Plans With First-Dollar Coverage?*, KFF (Apr. 13, 2015), https://www.kff.org/medicare/issue-brief/medigap-enrollment-among-new-medicare-beneficiaries/.

[137]Bonnie Burns, Policy Specialist, California Health Advocates, Strengthening Public and Private Long-Term Services and Supports, 7 (Aug. 1, 2013), http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Bonnie-Burns-Testimony.pdf. Ms. Burns is an expert on Medigap, she serves as a consumer representative on the National Association of Insurance Commissioners (NAIC); she has testified before Congress on Medigap issues. Notes on file with author. *See also*, William G. Schiffbauer, Esq., Schiffbauer Law Office. Mr. Schiffbauer's practice is in the areas of federal and state legislation and regulation relating to health insurance, health plans, and health care policy, ERISA, Medicare, Medicaid, and health insurance tax-related matters. Notes on file with author.

[138] Close the Medigap Act of 2021, *supra* note 125.

Affordable Care Act (ACA).[139] Because Medigap plans are permitted[140] to consider preexisting conditions in certain situations for setting premiums and for issuing coverage, they provide fewer protections for individuals with preexisting conditions than most insurance post-ACA. After passage of the ACA, which provided comprehensive protections for people preexisting conditions, this is out of sync with the rest of the insurance market. Prior to the ACA taking effect in 2014, people with pre-existing health conditions were often denied coverage or charged higher premiums for individual market coverage. [141] Post-ACA, people with pre-existing health conditions have not had their health conditions affect their access to health insurance or raise their premiums.[142] This is particularly significant for the Medicare population, who as a group have a higher rate of preexisting conditions. According to CMS data, of all non-dual-eligible Medicare beneficiaries in 2017, 66% were living with two or more chronic conditions.[143] Therefore legislation that would prohibit insurers from factoring preexisting conditions into coverage or premium setting would impact a substantial portion of the Medicare population.

The legislation would also extend protections to other individuals, including those enrolled in Medicare Advantage for more than 12 months, who wish to switch back to the traditional

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[139] Assistant Sec'y for Public Affairs (ASPA), *Pre-existing Conditions*, HHS.GOV (Jan. 31, 2017), https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html; *see also* Ctr. For Medicare & Medicaid Serv. (CMS), *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform,* CMS.GOV, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-OtherResources/preexisting.

[140] Though insurers are permitted to consider preexisting conditions in certain situations, experts state that this may be more limited in practice, *See*, Burns, *supra* note 137.

[141] Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt & Karen Pollitz, *Pre-Existing Condition Prevalence for Individuals and Families,* KFF (Oct. 4, 2019), https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/.

[142] *Id.*

[143] Kristen Riley, Thomas Tsai, Jose Figueroa & Ashish Jha, *Managing Medicare Beneficiaries with Chronic Conditions During the COVID-19 Pandemic,* THE COMMONWEALTH FUND (Mar. 18, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/managing-medicare-beneficiaries-chronic-conditions-covid#6.

Medicare program after the trial period ends. [144] This would provide individuals with a meaningful opportunity to try Medicare Advantage and then switch to traditional Medicare if they determine Medicare Advantage is not working for them.

The Medigap Consumer Protection Act of 2019 (S.2428),[145] introduced by Senator Sherrod Brown of Ohio, also expands Medigap consumer protections. Among other things, Sen. Brown's bill would also expand guaranteed issue of Medigap policies to several groups of individuals, including those with Medicare under age 65 and individuals enrolled in Medicare Advantage who choose to switch to traditional Medicare after their 12-month MA trial period ends.[146]

Absent federal legislation making expanded Medigap consumer protections available uniformly across the country, consumer protections vary widely. Only a handful of states currently have broader consumer protections for Medicare beneficiaries over 65. Connecticut, along with New York and Massachusetts, has a continuous enrollment period.[147] It is worth exploring how those markets function and examining how additional enrollment periods could be expanded on a national level in a way that balances ensuring a stable market with additional consumer protections.

In Connecticut, continuous enrollment coupled with community rating, ensures that beneficiaries have access to Medigap plans if their situation makes it such that their Medicare Advantage plan is no longer serving them well. They are able to switch to traditional Medicare and enroll in a Medigap plan to cover the out-of-pocket costs in Medicare. At the time of this writing, Connecticut has 14

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[144] Close the Medigap Act of 2021, *supra* note 125.
[145] *See* Medigap Consumer Protection Act of 2019, S. 2428, 116th Cong. (2019).
[146] *Id*.
[147] Boccuti, Cristina et al., *Medigap Enrollment and Consumer Protection Vary Across States,* KFF (Jul. 11, 2018), https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/

companies offering various individual and group Medigap plans, indicating that there is market competition in the state.[148]

Maine has an annual enrollment period for Plan A, which allows individuals the right to purchase Medigap Plan A during an annual one-month open enrollment period.[149] The month can vary based on the company. An annual Medigap enrollment period should be studied to determine how to replicate nationally, with a focus on impacts on premiums.[150] The insurance market in Maine clearly has a level of competition as, at the time of this writing, there are 14 companies offering plan A.[151] In fact, two of the insurers go beyond the one-month requirement, and voluntarily elect to offer continuous enrollment into Plan A throughout the year.[152] This seems to indicate that the extended enrollment opportunities do not cause instability in the market; rather, some companies must see a benefit in extending the enrollment opportunity beyond the required one-month to 12 months. Consumer advocates knowledgeable about Medigap plans have called for annual enrollment periods in Medigap similar to the annual enrollment period in Medicare Advantage, and as a means of expanding access to supplemental insurance, while moderating the pricing fluctuations that could

[148] State of Connecticut Insurance Department, "Monthly Medicare Supplement rates for Standardized Plans, CT.GOV (updated Sept. 27, 2021), https://portal.ct.gov/-/media/CID/1_LifeHealth/Medicare_Supplement_Insurance_Rates.pdf.

[149] ME. REV. STAT. ANN. 24-A § 5012 (2021), https://casetext.com/statute/maine-statutes/title-24-a-maine-insurance-code/chapter-67-medicare-supplement-insurance-policies/section-5012-annual-guaranteed-issue-period. This states, "[d]uring a guaranteed issue period of at least one month each calendar year, as established by the issuer, every issuer shall offer standardized Medicare Supplement Plan A, as defined by rule, to all applicants on a basis that does not deny coverage to any individual or group based on health status, claims experience, receipt of health care, or medical condition."

[150] This should be done while also aiming to include more than just the basic plan A in the annual enrollment.

[151] Maine Bureau of Insurance, *A Consumer's Guide To... Medicare Supplement Insurance (premium comparison chart)*, Dept. of Professional & Financial Regulation 8-12 (Sept. 2021), https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/consumer_guide_medicare_supplement.pdf

[152] *Id.* at 8-13.

arise from continuous enrollment.[153] Maine also extends the Medicare Advantage trial period to three years;[154] this is a significant expansion from the federal minimum of a one-year trial period. Extending the Medicare Advantage trial period is another consumer protection that should be explored at the federal level.

It is crucial to balance expanding access to consumer protections that have a focus on health equity, with the aim of maintaining reasonable and predictable premiums for all beneficiaries. A Medigap expert who has extensive knowledge of the Medigap insurance industry perspective highlights concerns about adverse selection. Reasoning that if individuals who are sicker are more likely to disenroll from Medicare Advantage to join traditional Medicare and obtain Medigap insurance, the pool of beneficiaries in Medigap plans would skew to be sicker and costlier individuals, resulting in increases in premiums for all beneficiaries, including those already in a Medigap plan.[155] The expert notes that Medicare Advantage plans have the ability to use risk adjustment[156] to address

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[153] Comments from Bonnie Burns, California Health Advocates. Ms. Burns is an expert on Medigap, she serves as a consumer representative on the National Association of Insurance Commissioners (NAIC); she has testified before Congress on Medigap issues. Notes on file with author.

[154] Chapter 275: Medicare Supplement Insurance Rule: 2009 Revision, § 12(B)(6), Guaranteed Issue for Eligible Persons, https://www.maine.gov/sos/cec/rules/02/031/031c275.doc.

[155] Schiffbauer, *supra* note 137.

[156] Risk adjustment in MA raises many separate issues. A September 2021 HHS OIG report highlighted some of the concerns. It was undertaken "because of concerns that MA companies may leverage both chart reviews and HRAs to maximize risk adjusted payments, without beneficiaries receiving care for those diagnoses." The OIG report's recommendations:

> CMS should (1) provide oversight of the 20 MA companies that had a disproportionate share of the risk-adjusted payments from chart reviews and HRAs; (2) take additional actions to determine the appropriateness of payments and care for the 1 MA company that substantially drove risk adjusted payments from chart reviews and HRAs; and (3) perform periodic monitoring to identify MA companies that had a disproportionate share of risk adjusted payments from chart reviews and

these concerns, while Medigap does not, also cautioning that limiting enrollment periods creates stability in the insurance market, allowing insurers to more accurately predict membership makeup and expected costs.[157] The expert warns that if Medigap enrollment opportunities are expanded, it would make those predictions more difficult, and could lead to instability. [158]

If expansions result in increased premiums for all beneficiaries to the point that the plans become cost prohibitive, that would undermine the purpose of such protections. Analysis and research on the complexity involved in pricing is necessary. The states that currently utilize broad protections should also be used to guide the discussion and development of proposals, while considering differing demographics across the country.

Though this paper focuses on Medigap protections, a few additional policy considerations naturally arise from the analysis. The need for an out-of-pocket cap in traditional Medicare is evident. A large share of beneficiary expenses come from out-of-pocket

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> HRAs. To assist CMS with its efforts, we will provide information on which companies had a substantially disproportionate share of risk adjusted payments from diagnoses that were reported only on chart reviews and/or HRAs. CMS neither concurred nor nonconcurred with our three recommendations and stated that it will take our recommendations under consideration as part of its ongoing process to determine policy options for future years.

See also Paul Van De Water, *Executive Order, Other Administration Actions Would Weaken Medicare*, CTR. ON BUDGET AND POLICY PRIORITIES (Nov. 7, 2019) https://www.cbpp.org/research/health/executive-order-other-administration-actions-would-weaken-medicare:

> Medicare's payment system attempts to correct for differences in the health status of plans' enrollees through a process known as "risk adjustment." Nonetheless, the Medicare Payment Advisory Commission estimates that MA plans are overpaid by about 1% compared to traditional Medicare because of the way they code their enrollees' health conditions. And some evidence indicates that that the overpayments may be even greater. In a recent study, for example, the Kaiser Family Foundation found that people who switched from traditional Medicare to MA had $1,253 (or 13%) less Medicare spending, on average, in the previous year than beneficiaries who remained in traditional Medicare, even after risk adjustment. This suggests that "basing payments to plans on the spending of those in traditional Medicare" — as under current law — "may systematically overestimate expected costs of Medicare Advantage enrollees," according to the Kaiser researchers.

[157] Schiffbauer, *supra* note 137.

[158] *Id.*

costs for health care. This fact, coupled with the financial situation of the average Medicare beneficiaries, makes the need for an out-of-pocket cap in traditional Medicare clear. As discussed previously, the out-of-pocket cap in Medicare Advantage on average is still relatively high given the financial circumstances of many Medicare beneficiaries. Many individuals still have cost-related difficulties with Medicare Advantage, especially beneficiaries of color. Some research has suggested that creating a more reasonable cap, such as a $3,500 annual cap on beneficiary spending for Medicare services, could alleviate much of the financial hardship for Medicare beneficiaries.[159] While such an out-of-pocket cap should be a component of the solution, it would not obviate the need for supplemental insurance. A lower cap would be helpful for middle income beneficiaries, but for lower income beneficiaries the cap is still too high to make supplemental insurance unnecessary. All such proposals must be examined within the context of the financial situation of Medicare beneficiaries. Creating a meaningful annual out-of-pocket cap, coupled with expanded access to Medigap policies would greatly improve the financial outlook for many beneficiaries.

Conclusion

Expansions in consumer protections for private Medigap supplemental insurance are necessary to promote health equity in the Medicare program. Without consumer protections to improve

[159]Cathy Schoen, Karen Davis, Christine Buttorff & Amber Willink*, Medicare Benefit Redesign: Enhancing Affordability for Beneficiaries While Promoting Choice and Competition,* THE COMMONWEALTH FUND, (Oct. 24, 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/medicare-benefit-redesign-affordability; *see also*, MEDICARE PAYMENT ADVISORY COMM'N, 112TH CONG., *March 2012 Report to Congress*, 10-27 (June 15, 2021) http://medpac.gov/docs/default-source/reports/jun12_ch01.pdf?sfvrsn=0.

access to Medigap plans, beneficiaries cannot easily exit from a Medicare Advantage plan in order to switch to traditional Medicare, even if Medicare Advantage is no longer serving their needs. This is a particularly concerning issue for older and sicker beneficiaries and beneficiaries of color. Beneficiaries with disabilities under age 65 are completely left out of federal protections. Broader consumer protections that are already in place in some states should be studied to determine their impact on beneficiary access, market competition and stability, and beneficiary premiums, to determine if they can be replicated at the national level.