Older Americans say they feel trapped in Medicare Advantage plans

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In 2016, Richard Timmins went to a free informational seminar to learn more about Medicare coverage.

"I listened to the insurance agent and, basically, he really promoted Medicare Advantage," Timmins said. The agent described less expensive and broader coverage offered by the plans, which are funded largely by the government but administered by private insurance companies.

For Timmins, who is now 76, it made economic sense then to sign up. And his decision was great, for a while.

Then, three years ago, he noticed a lesion on his right earlobe.

"I have a family history of melanoma. And so, I was kind of tuned in to that and thinking about that," Timmins said of the growth, which doctors later diagnosed as malignant melanoma. "It started to grow and started to become rather painful."

Timmins, though, discovered that his enrollment in a Premera Blue Cross Medicare Advantage plan would mean a limited network of doctors and the potential need for preapproval, or prior authorization, from the insurer before getting care. The experience, he said, made getting care more difficult, and now he wants to switch back to traditional, government-administered Medicare.

But he can't. And he's not alone.

"I have very little control over my actual medical care," he said, adding that he now advises friends not to sign up for the private plans. "I think that people are not understanding what Medicare Advantage is all about."

Enrollment in Medicare Advantage plans has grown substantially in the past few decades, enticing more than half of all eligible people, primarily those 65 or older, with low premium costs and perks like dental and vision insurance. And as the private plans' share of the Medicare patient

pie has ballooned to 30.8 million people, so too have concerns about the insurers' aggressive sales tactics and misleading coverage claims.

Enrollees, like Timmins, who sign on when they are healthy can find themselves trapped as they grow older and sicker.

"It's one of those things that people might like them on the front end because of their low to zero premiums and if they are getting a couple of these extra benefits—the vision, dental, that kind of thing," said Christine Huberty, a lead benefit specialist supervising attorney for the Greater Wisconsin Agency on Aging Resources.

"But it's when they actually need to use it for these bigger issues," Huberty said, "that's when people realize, "Oh no, this isn't going to help me at all.'"

Medicare pays private insurers a fixed amount per Medicare Advantage enrollee and in many cases also pays out bonuses, which the insurers can use to provide supplemental benefits. Huberty said those extra benefits work as an incentive to "get people to join the plan" but that the plans then "restrict the access to so many services and coverage for the bigger stuff."

David Meyers, assistant professor of health services, policy, and practice at the Brown University School of Public Health, analyzed a decade of Medicare Advantage enrollment and found that about 50% of beneficiaries— rural and urban—left their contract by the end of five years. Most of those enrollees switched to another Medicare Advantage plan rather than traditional Medicare.

In the study, Meyers and his co-authors muse that switching plans could be a positive sign of a free marketplace but that it could also signal "unmeasured discontent" with Medicare Advantage.

"The problem is that once you get into Medicare Advantage, if you have a couple of chronic conditions and you want to leave Medicare Advantage, even if Medicare Advantage isn't meeting your needs, you might not have any ability to switch back to traditional Medicare," Meyers said.

Traditional Medicare can be too expensive for beneficiaries switching back from Medicare Advantage, he said. In traditional Medicare, enrollees pay a monthly premium and, after reaching a deductible, in most cases are expected to pay 20% of the cost of each nonhospital service or item they use. And there is no limit on how much an enrollee may have to pay as part of that 20% coinsurance if they end up using a lot of care, Meyers said.

To limit what they spend out-of-pocket, traditional Medicare enrollees typically sign up for supplemental insurance, such as employer coverage or a private Medigap policy. If they are low-income, Medicaid may provide that supplemental coverage.

But, Meyers said, there's a catch: While beneficiaries who enrolled first in traditional Medicare are guaranteed to qualify for a Medigap policy without pricing based on their medical history, Medigap insurers can deny coverage to beneficiaries transferring from Medicare Advantage plans or base their prices on medical underwriting.

Only four states—Connecticut, Maine, Massachusetts, and New York—prohibit insurers from denying a Medigap policy if the enrollee has preexisting conditions such as diabetes or heart disease.

Paul Ginsburg is a former commissioner on the Medicare Payment Advisory Commission, also known as MedPAC. It's a legislative branch agency that advises Congress on the Medicare program. He said the inability of enrollees to easily switch between Medicare Advantage and

traditional Medicare during open enrollment periods is "a real concern in our system; it shouldn't be that way."

The federal government offers specific enrollment periods every year for switching plans. During Medicare's open enrollment period, from Oct. 15 to Dec. 7, enrollees can switch out of their private plans to traditional, government-administered Medicare.

Medicare Advantage enrollees can also switch plans or transfer to traditional Medicare during another open enrollment period, from Jan. 1 to March 31.

"There are a lot of people that say, "Hey, I'd love to come back, but I can't get Medigap anymore, or I'll have to just pay a lot more,'" said Ginsburg, who is now a professor of health policy at the University of Southern California.

Timmins is one of those people. The retired veterinarian lives in a rural community on Whidbey Island just north of Seattle. It's a rugged, idyllic landscape and a popular place for second homes, hiking, and the arts. But it's also a bit remote.

While it's typically harder to find doctors in rural areas, Timmins said he believes his Premera Blue Cross plan made it more challenging to get care for a variety of reasons, including the difficulty of finding and getting in to see specialists.

Nearly half of Medicare Advantage plan directories contained inaccurate information on what providers were available, according to the most recent federal review. Beginning in 2024, new or expanding Medicare Advantage plans must demonstrate compliance with federal network expectations or their applications could be denied.

Amanda Lansford, a Premera Blue Cross spokesperson, declined to comment on Timmins' case. She said the plan meets federal network adequacy requirements as well as travel time and distance standards "to ensure members are not experiencing undue burdens when seeking care."

Traditional Medicare allows beneficiaries to go to nearly any doctor or hospital in the U.S., and in most cases enrollees do not need approval to get services.

Timmins, who recently finished immunotherapy, said he doesn't think he would be approved for a Medigap policy, "because of my health issue." And if he were to get into one, Timmins said, it would likely be too expensive.

For now, Timmins said, he is staying with his Medicare Advantage plan.

"I'm getting older. More stuff is going to happen."

There is also a chance, Timmins said, that his cancer could resurface. "I'm very aware of my mortality."