

As Seniors Get Sicker, They're more likely to Drop Medicare Advantage Plans

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Critics argue the plans can prove risky for seniors who need to see specialists, because they often face hurdles getting access. A recent GAO report adds new weight to the criticism.

By [Fred Schulte](#)

When Sol Shipotow enrolled in a new Medicare Advantage health plan earlier this year, he expected to keep the doctor who treats his serious eye condition.

"That turned out not to be so," said Shipotow, 83, who lives in Bensalem, Pa.

Shipotow said he had to scramble to get back on a health plan he could afford and that his longtime eye specialist would accept. "You have to really understand your policy," he said. "I thought it was the same coverage."

Boosters say that privately run Medicare Advantage plans, which enroll about one-third of all people eligible for Medicare, offer good value. They strive to keep patients healthy by coordinating their medical care through cost-conscious networks of doctors and hospitals.

But some critics argue the plans can prove risky for seniors in poor or declining health, or those like Shipotow who need to see specialists, because they often face hurdles getting access.

A recent [report](#) by the Government Accountability Office, the auditing arm of Congress, adds new weight to criticisms that some health plans may leave sicker patients worse off.

The GAO report, released this spring, reviewed 126 Medicare Advantage plans and found that 35 of them had disproportionately high numbers of sicker people dropping out. Patients cited difficulty with access to "preferred doctors and hospitals" or other medical care, as the leading reasons for leaving.

"People who are sicker are much more likely to leave (Medicare Advantage plans) than people who are healthier," James Cosgrove, director of the GAO's health care analysis, said in explaining the research.

David Lipschutz, an attorney at the [Center for Medicare Advocacy](#), says the GAO findings were alarming and should prompt tighter government oversight.

"A Medicare Advantage plan sponsor does not have an evergreen right to participate in and profit from the Medicare program, particularly if it is providing poor care," Lipschutz says.

The GAO did not name the 35 health plans, though it urged federal health officials to consider a large exodus from a plan as a possible sign of substandard care. Most of the 35 health plans were relatively small, with 15,000 members or fewer, and had received poor scores on other government quality measures, the report said. Two dozen plans saw 1 in 5 patients leave in 2014, much higher turnover than normal, the GAO found.

Medicare Advantage plans now treat more than 19 million patients, and are expected to grow as record numbers of baby boomers reach retirement age.

Kristine Grow, a spokeswoman for America's Health Insurance Plans, an industry trade group, says Medicare Advantage keeps expanding because most people who sign up are satisfied with the care they receive.

She says that patients in the GAO study mostly switched from one health plan to another because they got a better deal, either through cheaper or more inclusive coverage.

Grow says many Medicare Advantage plans offer members extra benefits not covered by standard Medicare, such as fitness club memberships or vision or dental care, and do a better job of coordinating medical care to keep people active and out of hospitals.

"We have to remember these are plans working hard to deliver the best care they can," Grow says. Insurers compete vigorously for business and "want to keep members for the long term," she adds.

Some seniors, wary of problems ahead, are choosing to go with traditional Medicare coverage. Pittsburgh resident Marcy Grupp says she mulled over proposals from Medicare Advantage plans but worried she might need orthopedic or other specialized health care and wanted the freedom to go to any doctor or hospital. She's decided on standard Medicare coverage and paid for a "Medigap" policy to pick up any uncovered charges.

"Everything is already in place," says Grupp, a former administrative assistant who turns 65 this month.

The GAO report on Medicare Advantage comes as federal officials are ramping up fines and other penalties against errant health plans.

In the first two months of this year, for instance, the federal Centers for Medicare & Medicaid Services [fined](#) 10 Medicare Advantage health plans a total of more than \$4.1 million for alleged misconduct that "delayed or denied access" to covered benefits, mostly prescription drugs.

In some of these cases, health plans charged patients too much for drugs or failed to advise them of their right to appeal denials of medical services, according to government records. Industry watchers predict more penalties are to come.

Last month, CMS officials ended a 16-month ban on enrollment in Cigna Corp.'s Medicare Advantage plans. CMS took the action after citing Cigna for "widespread and systematic failures" to provide necessary medical care and prescription drugs, policies officials called a "serious threat to enrollee health and safety."

A flurry of whistleblower lawsuits have surfaced, too. In late May, Freedom Health, a Florida Medicare Advantage insurer, [agreed to pay](#) nearly \$32 million to settle allegations that it exaggerated how sick some patients were to boost profits, while getting rid of others who cost a lot to treat.

Freedom Health allegedly kept a list of some "unprofitable" patients that it discouraged from staying in the health plan, while encouraging healthier, "more profitable" members to remain, according to the whistleblower suit. Federal regulations prohibit health plans from discriminating based on a person's health.

Asked by Kaiser Health News for comment, Freedom Health corporate counsel Bijal Patel emailed a statement that read, in part: "We agreed to resolve the case so that we can continue focusing on providing excellent care."

Casey Schwarz, a lawyer with the Medicare Rights Center, a consumer service organization, notes that health plans are required to have a formal process for patients to appeal denials of medical services. She says patients should know their rights and insist on them.

"We want people to vote with their feet and leave plans not serving them," Schwarz says.

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