

**Improving the Transition for Medicare Beneficiaries When  
Medicare Managed Care Plans Leave the Market**

**May 2010**

**Center for Advocacy for the Rights and Interests of the Elderly (CARIE)  
Dorothy S. Washburn Legislative Committee  
100 South Broad Street  
Suite 1500  
Philadelphia, PA 19110  
[www.carie.org](http://www.carie.org)**



## **Improving the Transition for Medicare Beneficiaries When Medicare Managed Care Plans Leave the Market**

### Background

In early fall 2009, Independence Blue Cross announced it would be discontinuing its Keystone 65 Complete plan, a Special Needs Plan, and its Keystone Value Plan, a zero premium Medicare Advantage plan, as well as its Personal Choice PPO plan in Chester, Delaware and Montgomery Counties. Later in the fall, Aetna and Evercare announced the discontinuation of additional Medicare Advantage plans. In sum, Medicare beneficiaries in Southeastern Pennsylvania were facing the loss of several Medicare Advantage plans impacting approximately 64,550 Medicare beneficiaries, including about 32,050 dually eligible beneficiaries. (The majority of beneficiaries were enrolled in Blue Cross plans.) These plan discontinuations, when coupled with Medicare's Annual Open Enrollment Period, placed a huge strain on the local APPRISE (Pennsylvania's State Health Insurance Assistance Program or SHIP) programs and other professionals in the community. The anxiety and fear among beneficiaries was high as they faced many complex choices and deadlines.

The purpose of this paper is to provide recommendations to the Centers for Medicare & Medicaid Services (CMS) and the Pennsylvania APPRISE program, or other SHIPs, to consider should this situation occur again, particularly when large numbers of beneficiaries are affected by plan discontinuations. The Center for Advocacy for the Rights and Interests of the Elderly (CARIE), coordinates the Dorothy S. Washburn Legislative Committee comprised of legal, health and human services professionals as well as older consumers who monitor legislative and regulatory developments at the local, state and national levels in an effort to promote the well being of frail older adults. The following recommendations are based on our recent collective experience in working to assist numerous beneficiaries in the Philadelphia area understand their options and enroll into new plans within prescribed deadlines.

### CMS

1. **The letters CMS mailed to beneficiaries were inaccurate, too complicated and confusing.** The mailed communications from CMS contained inaccurate information and were overly complicated and confusing for beneficiaries. Keystone 65 Complete (a SNP) members received letters that were not tailored to those who are dual eligibles. The letters stated that those who did not choose a new Medicare Advantage plan would only have Medicare coverage. Nowhere did it mention that the individual would also have full Medicaid coverage. This is important for a beneficiary to understand since Medicaid functions as a supplement to the beneficiary's Medicare coverage. The letter even recommended purchasing Medigap insurance! In fact, the longest part of the letter was

about Medigap policies! There is absolutely no reason for someone with Medicare and Medicaid to purchase a supplement to Medicare and they should not have received this information. The letter also suggested that a beneficiary could only switch to a new Medicare Advantage plan between 10/1/2009 and 1/31/2010. However, dual eligibles can switch plans anytime. By emphasizing that beneficiaries who take no action will “only” have Medicare coverage and failing to mention that they will also have Medicaid coverage, the letter implied that the beneficiary needed to choose another Medicare Advantage plan in order to have complete coverage. As discussed above, this is incorrect. Worse, the letter directed beneficiaries to a dozen different companies which offer Medicare Advantage products, most of which charge substantial premiums. Sending consumers too many unrelated options put the burden on them to wade through the information to try to discern what specifically applied to them and increased the possibility that a poor choice would be made. Language, cultural and literacy issues exacerbated the problem for some beneficiaries.

**Recommendations:**

- a. Ensure accuracy of all communications.
  - b. Distribute more targeted mailings so that beneficiaries are not forced to sort through information that does not apply to their circumstances.
  - c. Review the literacy level of all print communications and ensure that all mailings do not exceed a sixth grade literacy level.
  - d. Make letters available in different languages.
  - e. Ensure that large-print fonts are used in mailings.
  - f. Utilize APPRISE/SHIP counselors and others to develop more consumer friendly, targeted and useful communication, particularly during situations involving loss of current coverage. For example, beneficiaries in each county should have received information specific to their options.
2. **CMS restricts the frequency of communication health insurers can distribute to current members.** Health insurance providers were restricted in terms of the frequency and content of information being distributed to members losing coverage. As information evolved and deadlines neared, it would have been helpful if insurers were authorized to provide additional mailings or call consumers with more information.

**Recommendation:**

- a. Review the policy that limits the frequency of communication from health insurance providers to its members, especially in regard to plan discontinuations.
3. **Not all consumers knew their current plan name.** Many times, when clients called APPRISE counselors requesting help finding a new plan, they didn't know what plan they were currently enrolled in. Since options for those with a regular Medicare Advantage plan differ from those with a Special Needs Plan, APPRISE counselors had to investigate what plan they had before proceeding. When faced with helping thousands of callers, it would have saved local APPRISE counselors valuable time if the plan had been known initially.

For example, one woman, "Mrs. T", called APPRISE for help in finding a new plan, after being directed to a local APPRISE program by her insurance company. Since "Mrs. T" did not know which specific plan she had, the APPRISE counselor attempted to determine which plan "Mrs. T" had through the medicare.gov website. However, this information about a beneficiary's plan is inconsistent on Medicare's website and in "Mrs. T's" case; it did not indicate a plan. As a result, "Mrs. T" and the APPRISE counselor had to call the insurance company directly to attain this information. This is a situation that could have been easily prevented if "Mrs. T" was aware of the name of her specific plan. To avoid this initial confusion and to save time for consumers and SHIP programs with limited funds, we recommend the following:

**Recommendations:**

- a. Specify to which plan the beneficiary is enrolled in all communications regarding plan discontinuations sent to beneficiaries from CMS and insurers.
  - b. Require health insurance companies to print the specific plan name on the member's card.
  - c. Improve the availability of the beneficiary's plan information provided on the medicare.gov website.
4. **Medicare's website and toll free number need to be featured in all communications.** Many younger clients and the children of beneficiaries who were losing their plan called APPRISE counselors for the Medicare website so they could compare available health care and prescription plans. Many callers expressed frustration that they had spent so much time on the telephone trying to obtain information from the insurance company and APPRISE when they could have easily accessed that

information on Medicare's website. Medicare's website should also have clearer and easier linkages to state SHIP programs.

**Recommendations:**

- a. Make medicare.gov and the toll free telephone number clear and more prominent on all communication.
- b. Permit insurance companies and their customer service representatives to provide the Medicare website to consumers who call them.
- c. Increase visibility and simplify linkages to SHIPs on Medicare's homepage.

5. **Part D auto enrollment occurred in early December without notifying APPRISE or the public.** Apparently, the Part D auto-enrollment process happened in early December for those who did not select a plan. It would have been beneficial for APPRISE counselors and other professionals to have known this beforehand, as it would have alleviated confusion, saved time, and prevented problems related to those who selectively enrolled in a plan during this time. For example, one client experienced this confusion when he enrolled into a Medicare Advantage plan with prescription drug coverage (MA-PD) on the same day that the Part D auto-enrollment occurred, unbeknownst to him. The auto-enrollment into the Part D Plan automatically disenrolled him from the plan he had chosen. This man called APPRISE when he received a card from the Part D plan but not from the plan he signed-up for. The APPRISE counselor had to investigate what had occurred and then correct the problem to ensure the consumer's choice.

Of additional concern regarding the Part D auto-enrollment process is that every beneficiary that we know of in Philadelphia was auto-enrolled, was enrolled into the AmeriHealth plan. We were under the impression that beneficiaries would be randomly assigned to and enrolled in any of the eleven Part D plans with premiums under the benchmark amount of \$32.09, not solely the AmeriHealth Advantage PDP. Fortunately this plan offered a good formulary for beneficiaries but seemed counter to CMS policy.

**Recommendations:**

- a. Provide a timeline for APPRISE/SHIP counselors and professionals in the community outlining when auto-enrollment is scheduled to occur as well as the plans included.
- b. Provide the criteria or formula used to determine auto-enrollment assignment into Part D plans.

6. **Information was not communicated to professionals in the aging and disability network.** General information about the plan discontinuations, the implications of the discontinuations and the options for beneficiaries were not communicated to professionals in the aging network. This caused inconsistencies in the information that was being shared with beneficiaries, especially in terms of plan-specific and county-specific information.

**Recommendations:**

- a. Devise a talking point fact sheet tailored to the particular circumstance and the particular county.
  - b. Distribute or make the fact sheet available once all plan options have been finalized to all care managers, social workers, and anyone in the community to ensure accurate information is being communicated.
7. **Those not dually eligible face limited options.** Non dual-eligible beneficiaries who faced plan discontinuation are locked into their new plan for the calendar year. Consumers who are not satisfied with their new plan should not be locked in for another year. Especially given the confusion, some beneficiaries may not have realized that their coverage ended and they reverted back to traditional Medicare.

Additionally, because non dual-eligible beneficiaries are not auto-enrolled into a Part D Plan, those who enrolled into a new plan after December 31<sup>st</sup> because of the extended enrollment period went without prescription drug coverage until their new plan took effect in February.

**Recommendations:**

- a. Allow a special enrollment option for those who are not dual eligible and who must enroll in a plan or are reverted to traditional Medicare due to discontinuation of current coverage. These individuals should be permitted to make an additional change in coverage during the calendar year.
  - b. Clearly communicate the potential for this coverage gap to all non dual-eligible beneficiaries should they wait to enroll into a new plan *after* their current plan ends.
  - c. Provide a way for these beneficiaries to access their medications should they find themselves in this short-term coverage gap.
8. **CMS should monitor the customer service being provided by insurance providers during these transitions.** Independence Blue Cross (IBC) provided unsatisfactory customer service to their current

members losing coverage. When members called to discuss their options, IBC representatives did not provide a sufficient level of information. IBC contracted with ICT group who simply made cold transfers to APPRISE or merely told callers to call APPRISE with no explanation. Many callers still thought they were talking to someone from IBC when they were actually talking with an APPRISE counselor. Others thought they had been transferred to their new insurance company. For the Keystone 65 Complete clients, many of the callers did not understand that they had Medicare and Medicaid or that they would still have this coverage the following year. IBC customer service representatives should have explained the option of traditional Medicare, Medicaid, (including the use of an Access card), and Part D-Rx only plan. Some callers in Philadelphia who contacted APPRISE counselors assumed their only option was Bravo.

**Recommendation:**

- a. Do not allow insurers to cold transfer calls. Consumers should be advised and give permission to have a call transferred.
- b. Require that Insurance companies' customer service representatives be better trained and supported in providing needed information to consumers particularly during these transitions.
- c. Monitor insurers' customer service representatives including actually calling customer service to determine how calls are handled and the accuracy of information provided.

**The Pennsylvania APPRISE Program**

- 9. The local APPRISE programs were not equipped to respond to the onslaught of callers needing help.** The local APPRISE sites were not adequately staffed (some use volunteers only) and were not prepared to respond to the volume of calls received. When additional funding was distributed to the sites to hire temporary staff, it was already two months after termination letters were sent and calls had already overwhelmed local programs.

**Recommendation:**

- a. In the future, the Pennsylvania APPRISE program should initiate a more rapid response in terms of financial resources, suggested strategies, and information to support local APPRISE programs faced with the responsibility of responding to an excessive number calls by the deadlines imposed by CMS.

10. **There was an increased need for additional community outreach sessions.** There were not enough community outreach sessions held jointly with insurers explaining to consumers their options and the process for selecting a new health care plan. For example, at a meeting sponsored by IBC, members expressed frustration and anger because they could not get any solid information about the Bravo plans.

**Recommendations:**

- a. Increase the number of APPRISE outreach sessions in the community. Since local programs were overwhelmed with calls, regional coordinators or other Pennsylvania APPRISE trained staff could be utilized in these unique circumstances to help.
- b. Increase coordination among local APPRISE counselors and the managed care providers so that at one meeting, members/clients could secure information from all entities if needed. By coordinating efforts, consumers could be provided with the information needed to make an informed choice.

11. **Other community agencies, providers and professionals were in need of information.** Other agencies and professionals needed information about what was occurring so that they could better help their clients.

**Recommendation:**

- a. The Pennsylvania APPRISE program should provide more targeted education and training for professionals in the aging and healthcare fields particularly so that beneficiaries are ensured accurate information to make an informed choice.

12. **There needs to be more direction in addressing the needs of persons with disabilities.** There were a number of people under 60 (Value Plan members and disabled) who needed assistance. These callers typically needed more time and assistance because their needs were much broader. APPRISE counselors are more accustomed to working with older adults and are not always aware of all available resources for persons with disabilities.

**Recommendations:**

- a. Enhanced resources and talking points related to the needs of persons with disabilities should be developed and disseminated to APPRISE counselors.
- b. The Pennsylvania APPRISE program may also want to consider developing guidance to recruit volunteers with disabilities to help fellow beneficiaries.

### Conclusion

When Medicare Advantage plans withdraw from the market, it creates a challenging situation particularly during annual enrollment. The recent process in Southeastern Pennsylvania felt decentralized for consumers and those trying to help them. Should a similar situation arise in the future, it would be helpful if CMS and the statewide SHIP program could take a more proactive and centralized role in coordinating efforts, making community linkages, and ensuring information is disseminated in a timely way. One final thought, as many states and Pennsylvania look to working more closely with private insurers to integrate health and long term care, these problems would be exacerbated when plans are changed. **Not only would consumers receiving long term care services need to select and enroll in a new Medicare plan but they would also need to have a new care plan established in a short amount of time.**

CARIE's Dorothy S. Washburn Legislative Committee is very concerned that safeguards be in place in the event that there are unexpected changes in Medicare plan coverage. We are available to help provide additional information or assist in any way to help advance these recommendations. Please contact Diane A. Menio at [menio@carie.org](mailto:menio@carie.org) or 267-546-3434 should you have any questions.

5/2010