

Medicare Complexity Taxes Counseling Resources Available to Beneficiaries

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As the next Medicare annual open enrollment period approaches—October 15 to December 7—millions of Medicare beneficiaries must decide whether to change their coverage options. This may include switching from original Medicare (Part A and B) to Medicare Advantage, shopping for a new Medigap policy, or changing to a different Part D prescription drug plan. In this qualitative study with volunteer counselors, consumer advocates, and insurance brokers, American Institutes for Research found that many beneficiaries are overwhelmed by Medicare’s complexity and could benefit from one-on-one counseling to help them make better choices. Although there are many printed and web-based materials available to help beneficiaries make more informed decisions, beneficiaries may be surprised by Medicare Advantage’s out-of-pocket costs and network limitations. They may be unaware of the limitations on switching Medigap plans and back to original Medicare from Medicare Advantage. Beneficiaries may not realize they need to purchase a separate Part D drug policy. During fall open enrollment, brokers and State Health Insurance Assistance Program (SHIP) counselors may struggle to meet the demand for assistance.

Medicare Complexity Grows

In 2015, 55.3 million elderly or disabled Americans—two groups frequently challenged by physical and mental health-related problems—relied on Medicare for health security.¹ Medicare has been highly successful in providing nearly universal coverage to the elderly, expanding access to up-to-date health care services, and considerably relieving the cost of these services to beneficiaries.² But Medicare can be complex and bewildering to beneficiaries as they try to sort through an alphabet soup of Medicare options—Parts A, B, C, and D—each covering different aspects of care with unique rules and requirements. Much of Medicare’s complexity stems from the program’s origins and evolution. Signed into law in 1965, Medicare was designed to ease the desperate needs of seniors aged 65 and older who had high health care costs but limited or no insurance coverage, especially for hospital care. After considerable political wrangling, Medicare was passed as two parts with separate financing structures and coverage for hospital care (Part A) and outpatient care (Part B).

¹ The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicaid Insurance Trust Funds. (2016). *The 2016 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>

² Moon, M. (1996). What Medicare has meant to older Americans. *Health Care Financing Review*, 18(2), 49–59. Retrieved from <https://www.ssa.gov/history/pdf/WhatMedicareMeant.pdf>

As the program expanded to cover additional Americans—for example, those with disabilities and end-stage renal disease—and offer new benefits and coverage options, Medicare became an increasingly disjointed patchwork of benefits and plans. Particularly notable was the Medicare Modernization Act, passed in 2003, which filled the prescription drug coverage gap with Medicare Part D. However, the lack of a maximum out-of-pocket limit—or catastrophic coverage—remains a glaring gap in Medicare coverage, placing beneficiaries without Medigap supplemental coverage at risk for large out-of-pocket costs.³

Originally, there were few incentives to control Medicare costs. But as spending grew more rapidly than projected, the need for cost controls became evident and led Congress to pass at least 10 milestone acts to reform Medicare.⁴ Among the reforms was the addition of a private plan option, Medicare Part C, known now as Medicare Advantage. Supporters of this approach expected that private sector competition and managed care could reduce costs better than unmanaged fee-for-service (FFS) Medicare. Current beneficiaries have two main coverage options:

- Original Medicare—Parts A and B with or without Part D for drug coverage and Medigap to offset Part A and B deductibles and coinsurance; and
- Medicare Advantage, which provides coverage at least equivalent to Parts A and B and may offer drug coverage; beneficiaries also can purchase a Part D prescription drug plan.

³ The Medicare Catastrophic Coverage Act of 1988 reduced out-of-pocket costs for hospital stays, established a cap on beneficiaries' Part B out-of-pocket costs, and added drug coverage. This Act was repealed after seniors with retiree coverage loudly protested over paying additional taxes for coverage offered by their former employers.

⁴ Blumenthal, D., Davis, K., & Guterman, S. (2015). Medicare at 50—origins and evolution. *Health Affairs*, 37(2), 479–486.

Medicare's complexity is challenging for seniors,⁵ particularly those with cognitive difficulties. Many beneficiaries do not choose the highest value plans—those offering the highest quality with the lowest cost—and they avoid switching plans because they fear that care may be disrupted, costs may be higher, or that they will need to learn a whole new set of rules and requirements.^{6,7} The reluctance to reexamine coverage each year is particularly problematic for seniors enrolled in Part D because the drug plans change radically year to year. The vast majority of seniors enrolled in Part D programs will pay more than is necessary and may even be enrolled in a plan that does not cover their medications.⁸

This issue brief describes the educational resources and personalized counseling services available to help beneficiaries navigate the maze of Medicare choices. The findings are based on interviews with State Health Insurance Assistance Program (SHIP) counselors, brokers, and employers about the support they provide to Medicare beneficiaries and the problems beneficiaries typically encounter (see Data Source section of this document).

⁵ Jacobson, G., Swooper, C, Perry, M., & Slosar, M. (2014, May). *How are seniors choosing and changing health insurance plans? Findings from focus groups with Medicare beneficiaries*. Retrieved from <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>

⁶ McWilliams, J. M., Afendulis, C. C., McGuire, T. G., & Landen, B. E. (2011). Complex Medicare Advantage choices may overwhelm seniors—especially those with impaired decision making. *Health Affairs*, 30(9), 1786–94. Retrieved from <http://content.healthaffairs.org/content/early/2011/08/16/hlthaff.2011.0132.full>

⁷ Jacobson et al., 2014.

⁸ Patel, R. A., Walbergh, M. P., Mai Y., McElroy, N., Mallya, A., Kim, A., et al. (2015). Medicare Part D optimization: Potential out-of-pocket savings through plan reexamination. *American Journal of Pharmacy Benefits*, 7(2), 84–91. Retrieved from http://www.ajpb.com/journals/ajpb/2015/ajpb_marchapril2015/medicare-part-d-optimization-potential-out-of-pocket-savings-through-plan-reexamination

Data Source

AIR researchers conducted semistructured phone interviews with 6 SHIP counselors, 4 independent Medicare brokers, 2 employer benefit managers, and 5 consumer advocates from August 2015 to January 2016. The research team used snowball sampling to identify potential participants who were located throughout the U.S. Independent brokers who represent a variety of insurance companies were recruited for the study rather than “captive” agents that sell only one company’s products. The interviews focused on the following questions: (1) How do independent Medicare brokers and SHIP counselors assist beneficiaries? (2) How do brokers and SHIP counselors differ? (3) What types of enrollment problems do beneficiaries typically bring to counselors and brokers? and (4) How do these problems impact beneficiaries?

In addition to the interview findings, AIR researchers also present results of an informal survey of employers based in a major central U.S. city. The employer survey answered the question, What health insurance counseling support do employers offer retirees who are transitioning into Medicare? The survey was conducted in collaboration with a large U.S. city’s business group on health organization.

Navigating Medicare Benefits and Choices

A provision in the Balanced Budget Act of 1997 created the National Medicare Education Program (NMEP)⁹ to educate beneficiaries through a variety of materials and resources, including the *Medicare & You* handbook and other printed materials. Later, additional information was added, including comparative Part D information through the Medicare.gov website, the Medicare Compare database, toll-free

telephone assistance, and a national open enrollment campaign. The 2016 directory of resources for beneficiaries published by NMEP lists approximately 68 different printed materials, web pages and websites, videos, and Part D and provider comparison tools that are available to educate beneficiaries about various Medicare coverage options and benefits.¹⁰

Even with this extensive portfolio of resources, many beneficiaries need personalized counseling to understand their options and make informed choices. The NMEP enlists advocacy groups, government organizations, employers, providers, and other groups to assist beneficiaries in learning about their benefits and choices. One personalized counseling resource is the SHIP, a state-run program that receives federal grants to train and manage a network of staff and volunteer Medicare counselors who provide free counseling to beneficiaries. SHIPs operate in all 50 states, Washington, DC, and two U.S. territories. Seniors also can seek personalized assistance from insurance agents or brokers, legally known by the term, “producers.” Brokers receive commissions from plan issuers and may represent one or many insurance companies. A third resource for some beneficiaries is employers that offer assistance to employees transitioning from employer-sponsored group health plans to Medicare. Finally, in keeping with their mission, some independent, nonprofit organizations such as the Medicare Rights Center offer free counseling services to beneficiaries.

Little is known about how brokers, SHIP counselors, and employers assist beneficiaries in transitioning to Medicare or in choosing coverage options. This issue brief examines the role of brokers, SHIP counselors, and employers in helping beneficiaries navigate Medicare options, how SHIP counselors and brokers differ, and the types of problems SHIP counselors and brokers typically encounter when helping beneficiaries to enroll in Medicare.

⁹ The Centers for Medicare & Medicaid Services National Training Program offers a library of resources to train groups and individuals in counseling seniors to make informed decisions.

¹⁰ Resources for Medicare Beneficiaries (ICN 905183). (2016). Medicare Learning Network, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/BenePubFS-ICN905183.pdf>

SHIPs and Brokers Take Similar Counseling Approaches

Many beneficiaries approach brokers and counselors wanting to find the lowest cost plan. These beneficiaries may not understand that there is more to consider than the premium amount, such as out-of-pocket costs incurred for services and in-network coverage of a preferred provider. Brokers and counselors usually begin a 1- to 2-hour session by educating beneficiaries about the differences between Medicare Advantage and original Medicare and explaining how the prescription drug plans work. They ask beneficiaries for a list of their doctors' names and prescription drugs and explore beneficiaries' needs and preferences, including financial limitations, risk tolerance, access to care when traveling, and health conditions that may lead to extra expenses.

Brokers and counselors also explore which of the two programs—Medicare Advantage or original Medicare—makes sense for a particular beneficiary. They research which plans cover the beneficiary's doctors and prescriptions and then provide the beneficiary with a list of plan options based on the beneficiary's preference for Medicare Advantage or original Medicare. Sometimes brokers and counselors do the research and narrow plan options before meeting with a beneficiary; in other cases, they use the online Medicare Advantage and Part D Plan Finder decision support tools to select coverage options during a session. The Centers for Medicare & Medicaid Services (CMS) makes the Medicare Plan Finder available to the public on [medicare.gov](https://www.medicare.gov). Neither brokers nor SHIP counselors are allowed to steer beneficiaries to a specific plan. However, study participants did note that some beneficiaries are uncomfortable making a selection themselves and ask for a recommendation.

"It's emotional—they [beneficiaries] are very, very scared...they may be scared by looking at cost and need to think about it. Tons of people didn't realize Medicare would cost them for retirement. They get really uptight. But sometimes if just learning that [it will cost them] for the first time, they are emotional, new to Medicare and on a very limited income," one SHIP counselor said.

After presenting a list of options, SHIP counselors are required to leave the plan selection up to the beneficiary; the brokers we interviewed followed this procedure as well. Medigap plans are organized into [10 different plans](#), each identified by a different letter. Medigap plans are standardized; each policy offers the same cost sharing and services. Given this, the lowest cost plan at a particular letter level is generally the best choice. After considering what drugs are covered by the plan, beneficiaries may choose to select a Part D plan based on the convenience of the in-network pharmacies, preference for higher premiums and lower out-of-pocket monthly costs, or vice versa, or by familiarity with a particular insurer. Past history with an insurer may make a particular Medicare Advantage plan attractive. The availability of perks such as reduced cost sharing, a gym membership, or extra dental, vision, and hearing coverage may induce beneficiaries to join a specific plan.

Brokers and Counselors Differ in Important Ways

The major differences between brokers and SHIP counselors are (1) compensation, (2) training, and (3) regulatory requirements (see Table 1). Although SHIP counselors are generally volunteers, they may also be SHIP employees. In contrast, brokers are paid a monthly commission by Medicare plans. This commission is usually a percentage of the monthly premium the beneficiary pays to the plan. One broker indicated that he does not serve the dual-eligible market—a lower income population that qualifies for both Medicare and Medicaid—because of the tendency for these beneficiaries to switch plans frequently during the year, which results in his not being fully compensated for his services. In general, SHIP counselors appear to work with lower income beneficiaries more than brokers, whose clients often have more financial resources.

Training. Another important difference between SHIP counselors and brokers is the training they receive. SHIPs recruit retired professionals, such as teachers and accountants, and require that they complete an intensive training program that may include a self-study module, classroom time, and a mentorship with an experienced counselor. One SHIP training

Table 1. How SHIP Counselors and Brokers Differ

	SHIP Counselors	Brokers
Compensation	Volunteer or employed by SHIP	Receive commission that varies by health plan
Plans represented	All	May be independent or employed by an insurer as their representative; independent agents represent multiple carriers; other agents are employed by a plan
Population typically served	Lower to middle income	Middle to higher income
Training	Complete classroom and mentorship training sponsored by SHIP program; attend updates and refresher classes	Complete a course and pass a test on Medicare plans to obtain state license in the state where they do business
Restrictions	Provide information, counseling, and assistance but cannot give specific advice	Clients must sign a scope of appointment in advance so there is agreement about the purpose of the meeting; cannot talk about certain products, such as cancer insurance, dental insurance, or life insurance; subject to oversight by their contracted health or drug plan; risk losing licensure if they don't comply with rules

coordinator indicated that a major thrust of the training is to teach counselors where to go for information because there is so much to know. A week-long training cannot cover every situation counselors will encounter.

A SHIP manager commented: “Sometimes we laugh and think, ‘Who would want to be a SHIP volunteer?’...you have to learn so much. You really, really have to want to help people. It’s difficult to understand federal health insurance. They also have to get a handle on employer group insurance, military coverage.”

In comparison, brokers are licensed by the state where they do business and must pass a licensure exam. Continuing education may be required by the state for the broker to be relicensed. Insurers also may require brokers to complete (1) a Medicare certification course and exam, such as that offered by [America’s Health Insurance Plans](#); (2) fraud, waste, and abuse training; and (3) product training prior to selling products.

Plans Represented. Brokers contract with insurers to sell their products. A broker that represents one or a limited number of plans may not present beneficiaries with the highest value options for their situation. However, independent brokers are not necessarily biased. They may represent most of the plans within a market. The brokers interviewed selectively opted out of representing plans that charge higher premiums for the same coverage compared to competitors. SHIP counselors screen beneficiaries for

financial assistance programs and some brokers may provide this service.

“To give you an example, at age 65, a Plan F, which is the most popular [Medigap] plan...the plan is exactly the same from company to company, and the rates can vary from \$158 to \$192, so it makes no sense for a person to purchase Plan F for \$192,” one broker said.

Restrictions. Brokers are required to follow CMS rules for meeting with the public. First, they must have beneficiaries sign a Scope of Appointment form so there is a clear understanding about the purpose of the meeting. Certain topics are off limits, such as life insurance or probing for names of friends and family. Plans must comply with [CMS marketing rules](#), and the plans in turn hold the brokers selling their products accountable for following strict rules of conduct for marketing and communications with beneficiaries.

“The state has certain requirements about what [information] seniors must get. CMS has certain requirements for components of a compliant presentation,” a broker said.

Handling Varying Family Situations

Brokers, SHIP counselors, and employers must deal with varying family situations. For example, a Medicare-eligible client may have a spouse who is not yet Medicare eligible or even children, or a client may need guidance on where their family members can obtain coverage. As a result, counselors and

brokers need to be familiar with Health Insurance Marketplace eligibility and enrollment resources if other sources of coverage are not available to beneficiaries' families.

"We have things called 'mixed Medicare.' Let's say one of the retirees, the former employee might be over age 65, but they may have a young wife and kids, so the retiree might be in Medicare but then we put the spouse and the children in active plans or in pre-65 depending on what age they are. So it gets really complicated for them, and the reason we do that, it's better pricing for them and better for risk, but it's hard for them to understand," an employer representative said.

Medicare Education Resources Used Selectively

Medicare beneficiaries are inundated with mail and ads about Medicare plans both when they turn 65 years old and during the annual fall open enrollment period. Some beneficiaries seek help because they are overwhelmed and unsure where to start. In other cases, after doing their own research, beneficiaries want a second opinion as a reassurance that they are on the right track. Brokers and counselors find that providing beneficiaries with more materials to read is not helpful to them.

Information tools used by SHIP counselors varied by state and even by individual SHIP. Some counselors described sharing materials across SHIPs and preferred tools such as comparisons, checklists, and timelines prepared by SHIPs to ones prepared by CMS. Some brokers liked to highlight key points using the tables and diagrams available in the [Medicare & You handbook](#), which is published by CMS and mailed to beneficiaries' homes. But when they begin discussing specific plans, both brokers and SHIP counselors are required to use the CMS-approved marketing materials developed by the plans.

"The *Medicare & You* handbook is helpful to a point, yes. It doesn't have a level of detail in it. But it's at least a good first start. It has gotten much better over the last 10 years, can point people to specific

pages—just like the Plan Finder has," a SHIP counselor said. "I think Medicare is trying to listen when folks complain. They're trying hard. But everything at CMS has to go through review with lawyers to make sure it's legally correct—they can't dumb it down so a regular person knows what it means."

The [CMS Plan Finder web-based search tool](#) is valued by SHIP counselors and brokers because it helps them to identify drug plans that have the beneficiary's medications on formulary and preferred pharmacies that are convenient to beneficiaries. However, they reported that beneficiaries have problems using the tool without help. This is changing somewhat as more tech-savvy baby boomers enter Medicare. Brokers and SHIP counselors view the list of plans identified through the Plan Finder as a starting point for their research. The formularies listed by the online tool are not always accurate or up to date, so brokers and counselors have to verify that the beneficiary's drugs are covered by double checking with the insurer's website.

"I do use the Medicare.gov website for the drugs as a starting point so it gives me an idea of what plans would make the most sense for them, whether it's Part D or Medicare Advantage... So it kind of gives me a pathway of discussion to go, but I always double check the meds on the company's website because we don't fully trust the Medicare.gov website," a broker said.

Similarly, a SHIP counselor said, "People don't know how to navigate Plan Finder. People may read the Medicare guide book, but I'm not sure [they will] use Plan Finder on their own. With all the different filters, they don't know how to use Plan Finder. I have never had someone come in on their own and said they used the Plan Finder on [their] own."

Saving Beneficiaries Money

When beneficiaries ask for assistance, many indicate that their first priority is finding a plan with low-cost premiums. Brokers and SHIP counselors spend a good deal of the session helping beneficiaries understand that lower premium plans are not

necessarily the lowest cost option when deductibles, coinsurance, and copayments are considered. They do this by calculating total costs for a year and taking into account expected use of services and then showing the average monthly cost to beneficiaries.

The beneficiary's drug list and plan drug formularies are a major driver of decisions—both in considering whether to select Medicare Advantage or original Medicare and then when deciding what Medicare Advantage or Part D plan to select. Brokers and SHIP counselors offer a number of tips on how to save on drugs, such as buying generics through lower cost retail stores, filling prescriptions at in-network pharmacies, and for those with lower incomes, signing up for [federal programs](#) that help pay for premiums. And, in some cases, a plan with the same costs and coverage as another plan may offer extra perks like gym memberships or a reduction in the premium if both spouses join.

“People who are really confused or have a hard time understanding, I would sit down and show them 12 months—if have original Medicare and Blue Cross supplemental and Part D plan, on average over the next 12 months if your drugs don't change, you'll be spending this per month on health care. And then we look at Medicare Advantage and say over the next 12 months here's your premium. Then we look at how many times they went to the doctor, how many times in hospital, etc., last year, put down the copays for those...” according to a SHIP counselor.

SHIP counselors and brokers also help beneficiaries save money by understanding how various plans work. For example, many Part D plans have preferred pharmacies, and beneficiaries may not understand that driving down the street to a preferred pharmacy might save them \$20 or \$30 a month on prescriptions, according to a SHIP counselor, who added, “We have a trained eye to look for that as we compare plans.”

Reassessing Changing Beneficiary Needs

Studies have shown that Medicare beneficiaries rarely revisit their plan selection during the Medicare fall open enrollment period, but they should.^{4,5,6}

The deductible and formulary for Part D plans can change drastically from year to year, catching beneficiaries off guard. In addition, some carriers may opt to leave the Medicare Advantage market. The brokers and SHIP counselors interviewed often contact beneficiaries during open enrollment and offer to review the fit between the beneficiary's Part D, Medigap, or Medicare Advantage plan and changes to their prescriptions and health in the previous year.

“In the Medicare Advantage world, there's a lot of disruption because the carriers change plans or decide to get out of that market. I tell clients we are going to be switching plans at least once every three years. Same thing with the prescription drugs; there's a lot of disruption. It's really the same approach [when they come back]. I call them and I say, there's a better plan in the marketplace or you need to find something new. I'm a busy guy between October 15 and December 7. I'm on the phone probably 10 hours a day,” one broker said.

“[Plans] can exit the market, they can enter the market, they can and do change their annual benefits, their cost sharing, what's covered, their formularies, sometimes those changes are to the benefit of individuals, sometimes they're not to the benefit of individuals. So even when you're in Medicare and you have made a choice, we often caution people, and counsel them to do their homework. You really need to assess how your plan is going to change next year, because just because your plan worked for you this year is no guarantee that it's gonna work for you next year,” according to a Medicare advocate.

Employers Provide Limited Counseling Support

Many people move to Medicare coverage from employer-sponsored health insurance and look to employers for guidance during the transition. In addition to interviewing current and former benefits managers at Fortune 500 companies, AIR researchers worked with a business health group in a centrally located major city to learn about the health insurance counseling support that employers offer retirees. Private, public, and government employers of all sizes were surveyed.

About one-third of the 36 employers responding to the survey offered health care coverage as a retirement benefit. Nineteen (53%) companies offered retiree health plan counseling, and, of those that did provide assistance, seven (37%) referred retirees to an outside vendor and six (30%) offered internal information sessions. The vast majority of employers (66%) directed retirees to Medicare for assistance, while a few referred retirees directly to SHIP counselors or the local Area Agency on Aging (n = 5, 14%) or a Medicare broker (n = 3, 8%). In an interview with two benefits managers from Fortune 500 companies, they indicated that their companies send retirees enrollment packets each year and outsource counseling to a large benefit manager. The benefit manager staffs call centers with customer service representatives who follow scripts describing retiree plans but do not offer advice.

The SHIP counselors and brokers interviewed believed that employers are wise to refer employees to groups that routinely provide Medicare information rather than risk providing inaccurate information. One frequently mentioned problem was Medicare-enrolled employees continuing to make pre-tax contributions to a health savings account (HSA). According to Internal Revenue Service rules, HSA contributions are not allowed starting the first month a beneficiary is enrolled in Medicare. Beneficiaries that continue to fund an HSA risk penalties.¹¹

“A lot of insurance administrators at big businesses are not able to educate their employees well about Medicare,” according to a SHIP administrator. “We wish that they would all forward their people to the SHIP instead of trying to answer questions about Medicare. Because a lot of times, it’s not always correct. If something could be put in place for all insurance administrators to be aware of the SHIP, and direct their retirees to them, that would be wonderful.”

Common Problems Beneficiaries Encounter

Over the course of the interviews, multiple participants cited Medicare’s complexity as a general challenge for many beneficiaries. They also identified other common issues encountered by beneficiaries, including higher than expected Medicare Advantage out-of-pocket costs; limitations on changing Medigap plans and switching from Medicare Advantage back to original Medicare; unexpected and disruptive Part D formulary changes; and losing Marketplace low-income subsidies when they become Medicare eligible.

Surprised by Medicare Advantage out-of-pocket costs and network limitations. Medicare beneficiaries may buy a Medicare Advantage plan because of the low premiums, not realizing that the cost-sharing requirements can be substantial at the point of service. When confronted with the need for surgery or other high-cost care, beneficiaries may be surprised to learn that they are liable for cost sharing under Medicare Advantage under the specific terms of their plan up to the out-of-pocket maximum, which was as high as \$6,700 in 2016.¹²

A representative from a consumer advocacy organization said, “There’s not one right choice for everyone. People have different appetites for change and risk. Some are happy to switch docs and pharmacies if that means saving money; others have a top priority of keeping health care providers in place and are comfortable with paying more for that.”

Beneficiaries may not understand the in-network limitations under Medicare Advantage plans. As a result, they may find that they do not have routine access to care while traveling or that their preferred provider is not covered at all or is only covered at a reduced amount. The SHIP counselors and brokers we interviewed seemed to carefully explain Medicare Advantage’s network restrictions to beneficiaries and, possibly because of this, they did not mention specific instances where their clients unknowingly saw an out-of-network provider.

¹¹ Internal Revenue Service. (2016). *Publication 969: Health savings accounts and other tax-favored health plans*. Retrieved from <https://www.irs.gov/pub/irs-pdf/p969.pdf>

¹² Medicare Matters, National Council on Aging. (n.d.). Original Medicare and Part D vs. Medicare Advantage. Retrieved from <https://www.medicarematters.org/coverage/compare/>

“People will see that a Medicare Advantage plan is really cheap and ask if they should do that. I try to always explain to people that you get what you pay for; in one option you’re giving up freedom, and in the other you’re buying freedom. And that’s really the difference between the premiums,” an employer benefits manager said.

Limitations on switching Medigap plans and back to original Medicare from Medicare Advantage. Beneficiaries can freely switch to Medicare Advantage from original Medicare during open enrollment, but switching in the other direction comes with [restrictions](#) and costs. After initial enrollment, beneficiaries can be denied coverage by Medigap plans or they may be required to pay higher premiums than they would have if they had chosen original Medicare initially. There are exceptions, such as moving out of the plan service area or a plan being discontinued. Some states require all Medigap plans to offer coverage to those who enroll late. Beneficiaries do have an initial trial period in the first year of Medicare Advantage enrollment during which they can switch back to original Medicare and enroll in a Medigap plan; this switch often occurs after beneficiaries receive an unexpected bill for services while enrolled in a Medicare Advantage plan.

“Some states require Medigap plans sold in that state to be offered continuously. Like Connecticut and New York, I think offer—require—Medigap plans to do that. So the transition in those states is a lot easier. But in most states where a state law has not supplemented the federal requirements in that way, that can be a difficult transition. It’s much harder to go from Medicare Advantage to Medigap in most places, than it is to do the reverse. Because Medicare Advantage has to be open to all comers on an annual basis, with the exception of folks with kidney disease,” according to a consumer advocate.

Disruptive Part D formulary changes. In addition to changes announced during open enrollment for the coming coverage year, Part D plans can change their formulary and pharmacy network at any time during the year, creating problems for beneficiaries who have chosen a plan because the plan covers their

drugs and preferred pharmacy. Aside from losing coverage for a particular drug, formulary changes can make it difficult for beneficiaries with high drug expenses who have fallen into the coverage gap (donut hole), where they are responsible for the full cost of formulary drugs up to a maximum amount. The coverage gap is reached once a certain amount is spent for covered drugs. Nonformulary brand name drugs are not counted in the out-of-pocket limit that must be met before catastrophic coverage kicks in. Affordable Care Act provisions are slowly reducing the coverage gap each year until 2020, when the coverage gap will be eliminated and beneficiaries will pay 25% of their generic drug costs and formulary brand name drug costs. Beneficiaries generally pay the full costs of nonformulary brand name drugs unless an exception is obtained from the plan.

“We work so hard to get the drugs fixed and then as of March, they can change all the formularies... So here, we spend all this time to get them the right plan and the formularies can all change. And their health changes, so it’s an ongoing issue with folks. So there are many moving components in this, but in my opinion, I think the drug side is the most confusing and the toughest part of this whole thing,” one broker said.

Newly enrolled beneficiaries don’t understand how Medicare coverage works. Once enrolled, many beneficiaries do not understand how the different components of original Medicare fit with one another and do not realize that not all services are covered. For many beneficiaries new to Medicare, their reference point is employer coverage or coverage from the federal or state marketplaces where one health plan covers a comprehensive package of hospital and ambulatory services and drugs. They may be unaware of the need to purchase a separate drug policy. Some beneficiaries assume that supplemental coverage is comprehensive and covers not only the 20% out-of-pocket cost for allowable services they are responsible for under traditional Medicare but also all services that a doctor recommends. They may not realize that there are services that Medicare [does not cover](#) or that these services will not be covered under their Medigap policy either.

This includes costs for off-label uses of drugs and more frequent screenings than allowed by Medicare.

“Number one question around claims is if Medicare didn’t cover something and the supplemental plan will not cover it. Why? Because they were left with the perception somehow through their purchasing process that a supplemental plan would cover everything that Medicare didn’t, even though that’s not actually the case,” said an insurer representative.

Losing Marketplace low-income subsidies when becoming Medicare eligible. For some low-income seniors who have been receiving subsidies for premium and cost-sharing expenses in the Health Insurance Marketplace, enrollment in Medicare means higher costs. Once they become Medicare eligible, they no longer qualify for financial assistance through the Marketplaces, and it is against the law to sell a Marketplace plan to someone enrolled in Medicare Part A. However, low-income Medicare beneficiaries may be eligible for Medicaid assistance either through (1) full Medicaid coverage, which supplements Medicare coverage; or (2) through the Medicare Savings Program, which partially covers Part B premiums for those with incomes from 100% to 135% poverty and, in some cases, cost sharing for beneficiaries with incomes below 100% of the federal poverty level (FPL). People with limited income who meet an assets test may get help with drug benefits through Medicare’s Extra Help program. However, beneficiaries with incomes between 138% and less than 400% of the FPL who were eligible for Marketplace subsidies generally lose out.

“Inequity between folks who are eligible for assistance in Medicaid and the Exchanges, yet are no longer eligible once they hit Medicare is an issue, and I think it will only grow over time as more people will be transitioned from the exchanges into Medicare,” a Medicare advocate said.

Medicare Open Enrollment Period Overloads Counseling Capacity

Medicare’s open enrollment period occurs every year from October 15 through December 7. During this period, beneficiaries can select a different Medicare Advantage plan or Part D plan or switch from Medicare Advantage to original Medicare (Parts A and B) or vice versa. Brokers and SHIP counselors are under pressure during open enrollment to meet the demand for assistance and report that it is difficult to provide beneficiaries with needed support to make informed changes. Because of time limitations, they often focus on assisting beneficiaries with selecting a drug plan.

“They have overlapped open enrollment for ACA [Affordable Care Act marketplace coverage] with the annual election period for Medicare. ... Access to an agent and getting the time/attention you need with an agent can be a concern. Maybe the time and attention that should be given is not what it should be, and this is not good for the Medicare beneficiary,” according to one broker interviewed for the study.

Beneficiaries who wish to enroll in Medigap for the first time after their initial Medicare eligibility period or switch Medigap plans can do so throughout the year, but such a move is restricted because coverage is not guaranteed. In most states, Medigap enrollment is guaranteed only under [specific conditions](#), such as a Medicare Advantage plan leaving the market or the beneficiary moving out of the service area.

Policy Implications

Although there are many educational materials and resources available to Medicare beneficiaries, the program’s complexity poses challenges for many seniors, especially those with cognitive impairments. At no cost to the beneficiary, SHIP counselors and independent brokers provide an important service by guiding beneficiaries through the plan selection process then reaching out to beneficiaries to reevaluate their plan options during fall open enrollment.

Because of the compensation structure, lower income beneficiaries may not have access to brokers. SHIP appears to be a highly cost-effective way to provide one-on-one support to help lower income beneficiaries make more informed choices about their coverage options. There are about 15,000 SHIP counselors available across the country, and about 57% are trained volunteers.¹³ In 2013, \$51.9 million was spent on the SHIP, which provided one-on-one counseling to more than 2.6 million of the 52.5 million Medicare beneficiaries at a cost of less than \$20 per beneficiary served. Our rough estimate is conservative and does not account for the numerous beneficiaries who attended workshops and received other types of assistance.

Despite these facts, SHIP was deemed “an unnecessary federal program” in June 2016 when the U.S. Senate Appropriations Committee voted to cut SHIP funding from the fiscal year 2017 \$93 billion Labor, HHS/Education appropriations bill.¹⁴ Although the bill has not advanced to a full Senate vote, the committee approval may signal a lack of awareness of the program’s benefits to seniors, including significant cost savings. For example, the Ohio Department of Insurance estimated that SHIP saved \$20.8 million in 2015 for Medicare beneficiaries in the state.¹⁵ Nationally, the SHIP budget accounted for less than 0.1% of the Medicare budget in 2015. Rather than eliminating SHIP funding, policy makers may want to consider how best to increase one-on-one counseling services to help beneficiaries save money and get the highest quality coverage at the lowest cost.

The transition from employer insurance coverage to Medicare after the age of full Social Security

benefit eligibility seems particularly problematic for beneficiaries¹⁶ and is an area where assistance from SHIP counselors can be expanded. The CMS website was updated recently with an [Employer Resources page](#) to help employers assist employees with obtaining information about transitioning to Medicare coverage. However, employers are poorly positioned to sort through Medicare’s complex enrollment information and help an employee figure out what enrollment rules apply to a particular set of circumstances. Rather than providing materials or tools to pass on to employees, employees may benefit most if CMS educates employers about SHIP and how they can refer employees to counselors who can provide tailored enrollment information. This may be an area for cross-agency collaboration between CMS and the Department of Labor’s Employee Benefits Security Administration, which oversees employer-sponsored health and welfare plans pursuant to the Employee Retirement Income Security Act, or ERISA.

¹³ Administration for Community Living. (n.d.). State Health Insurance Assistance Program. Retrieved from <http://www.acl.gov/Programs/CIP/OHIC/SHIP.aspx>

¹⁴ United States Senate Committee on Appropriations. (2016). *FY2017 Labor, HHS & Education Appropriations Bill cleared for senate consideration* [Press release]. Retrieved from <http://www.appropriations.senate.gov/news/majority/fy2017-labor-hhs-and-education-appropriations-bill-cleared-for-senate-consideration>

¹⁵ Ohio Department of Insurance. (2016). *Lt. Governor Taylor announces OSHIP Medicare educational program generated savings of \$20.8 million for Ohioans: Medicare awareness efforts earned first-place national ranking* [Press release]. Retrieved from <http://www.icontact-archive.com/eAL0LxRcKh6NzpzgHringswDV5aNcRec?w=4>

¹⁶ Paez, K., & Almeida, B. (2016). *Medicare enrollment maze puts older Americans at risk for financial penalties and coverage gaps*. Washington, DC: American Institutes for Research, Center on Aging.

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AIR is one of the world's largest behavioral and social science research and evaluation organizations. Our overriding goal is to use the best science available to bring the most effective ideas and approaches to enhancing everyday life. For us, making the world a better place is not wishful thinking. It is the goal that drives us. Our mission is to conduct and apply the best behavioral and social science research and evaluation towards improving people's lives, with a special emphasis on the disadvantaged.

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