

The Beneficiary Experience with Enrollment and Access



Every year, many people with Medicare struggle to choose a plan that best meets their needs. For newly-eligible enrollees and those re-evaluating their options, the Medicare Advantage (MA) plan comparison process can be complex and burdensome, undermining coverage choices. Once enrolled, these decisions and MA-specific plan features may limit enrollee access to care in unanticipated and harmful ways.

Enrollment

Most people new to Medicare are automatically enrolled because they are receiving Social Security when they become eligible, but a growing number are not.ⁱ These individuals must enroll on their own, taking into consideration specific timelines, intricate Medicare rules, and any existing coverage. Mistakes are common and carry serious consequences, including lifelong financial penalties, high out-of-pocket costs, disruptions in care, and gaps in coverage. People who choose to receive their benefits through MA face an additional hurdle: selecting a plan. This can be complicated, principally due to the **plan landscape**, inadequate **decision-making tools**, and **plan marketing tactics**.

Plan Landscape

Recent rule changesⁱⁱ and burgeoning profitsⁱⁱⁱ have led to seemingly endless numbers of MA plans and coverage choices. For 2023, beneficiaries had access to an average of 43 MA plans, more than double the number in 2018.^{iv} Choosing prescription drug coverage under Part D is additionally daunting, requiring analysis of 24 stand-alone and 35 MA drug plans, on average.^v These plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For many, this makes close analysis both critical and impossible.

Fundamentally, the number of MA plans and the variances across each can hinder sound decision-making.^{vi} Beneficiaries may become overwhelmed and select or continue with a plan that does not meet their needs or correspond with their preferences. This experience aligns with qualitative evidence,^{vii} and is supported by behavioral economics research, which suggests individuals who face a wide range of choices may have more difficulty making decisions, make poorer choices, or fail to act at all.^{viii} Indeed, few people with Medicare evaluate their options annually^{ix} or switch plans from one year to the next.^x This inertia can have detrimental impacts, like higher costs and problems accessing preferred providers. Enrollees who arguably have the

most at stake—those who are older, have lower incomes, are living with cognitive impairments, or have serious health needs—are also the least likely to review and change their coverage.^{xi}

Consumer Decision-Making Tools

Beneficiaries need clear, unbiased information and often personalized assistance to evaluate their coverage options. But too often, this need goes unmet. Although the federal government’s primary consumer tool, Medicare Plan Finder, has information about specific plans, it is limited in its utility. It can be confusing and unwieldy, and it omits vital details about cost comparisons, provider networks, and supplemental benefits. Further, MA provider directories are inaccurate and unreliable, making it difficult for beneficiaries to know if their doctors are in a given plan’s network. Other critical beneficiary-facing materials—like notices from the federal government to those approaching Medicare eligibility—are either non-existent, or, in the case of the Annual Notice of Change, missing actionable information. Highly trained State Health Insurance Assistance (SHIP) counselors offer crucial enrollment counseling, but the program is woefully underfunded. As a result, beneficiaries may look elsewhere for help, including to sources with their own, often distinct, financial interests.

Plan Marketing

MA plans are businesses, and their marketing efforts aim to attract enrollees and maximize profits. From the beneficiary perspective, this can muddle decision-making, make it difficult to know who to trust, and unduly influence coverage choices.

Nearly two-thirds of Medicare-eligible individuals report being overwhelmed by MA outreach and advertising.^{xii} While not all plan materials and ads are misleading, many are. Some seek to convey a false sense of urgency and compel beneficiaries to act, even if they are satisfied with their current coverage. Others appear designed to confuse by incorporating visual cues and messaging suggesting Medicare, and not a plan, is behind the ad. It is not uncommon for Medicare Rights’ Helpline callers to report responding to such outreach, only to be enrolled in a plan unknowingly and without their consent. These problems appear widespread^{xiii} and on the rise—complaints to Medicare about misleading marketing more than doubled between 2020 and 2021.^{xiv}

Confused and overwhelmed, many people rely on plans and their downstream entities, like brokers and agents, for help choosing coverage.^{xv} But these representatives are not always objective; they receive commissions, which may incentivize them to push an insurance product that is in their best interest but not the beneficiary’s.^{xvi}

Plans, brokers, and firms typically paint rosy pictures of MA, like the potential for “extra” benefits. This is particularly prominent in television advertisements. Such messaging can mislead consumers to conclude that all MA plans offer all the advertised benefits to all enrollees, or that the benefits are more generous than they are. With one-fourth of MA

enrollees reportedly being drawn in by supplemental benefits, it is clear they are a powerful marketing tool.^{xvii} However, given the scarcity of data on their utilization and value, it is unclear if they are anything more.

Discussion

The cluttered plan landscape and lack of accurate, unbiased decision-making tools can contribute to beneficiaries becoming overwhelmed by their coverage options and making poor or no enrollment choices. Some may rely on word of mouth or default to the same plan friends, neighbors, or family members have. Others may overly value information from sources more loyal to the plan than to its enrollees—such as TV spokespeople, brokers, and agents.^{xviii}

Sub-optimal enrollments carry severe consequences, including high costs, restricted provider access, and delayed care. And there are few remedies. If an enrollee makes a mistake, they may be stuck in a plan that does not meet their needs for up to a year, until the next open enrollment period, or may be locked into MA indefinitely because they can no longer purchase affordable Medigap coverage.

Access

Once enrolled in a plan, beneficiaries may face barriers to care, often due to **MA provider networks**. Plan use of **prior authorization** and any resulting **coverage denials** also present problems, as does the complex MA **appeals** process.

MA Provider Networks

Each MA plan has a network—a group of doctors, hospitals, and medical facilities they contract with to provide services. Generally, enrollee costs are lower for in-network care, as plans may offer no or reduced coverage for out-of-network claims.^{xix} While this system may help insurers manage costs and utilization, it can also limit enrollee access to care and result in significant expenses for out-of-network services.

Networks can also be difficult to understand and navigate. Some are too narrow, making care hard to find, access, and afford. MA disenrollment trends suggest this may be by design, as such restrictions can financially benefit plans by helping them avoid costly enrollees.^{xx} Most networks are also impermanent—doctors and hospitals can typically leave a plan anytime. Provider directories are meant to connect beneficiaries with accurate information about a plan's network but are often riddled with errors that obscure coverage realities.^{xxi} As a result, enrollees can be surprised to discover the true contours and costs of their plan.

Choice of provider is a key consideration for many beneficiaries, both when deciding between OM and MA and when selecting an MA plan. In 2022, 40% of new OM enrollees said they were primarily driven by provider choice.^{xxii} MA enrollees who value provider choice may try to select

a plan that reflects this preference. But unreliable directories and shifting networks can leave them at risk of losing—or never even having—the provider access and affordable care they seek. Typically, there is little recourse. Impacted enrollees may be stuck until the next open enrollment window. Since provider directory errors are likely to persist in the interim, finding care may remain a challenge.

Over the years, many studies have examined provider directory inaccuracies. Nearly all identify errors with provider contact and location information, network status, and availability.^{xxiii} Most recently, a May 2023 review by the U.S. Senate Finance Committee found “secret shoppers” could successfully use provider directories to make appointments only 18% of the time.^{xxiv} More than 80% of the listed providers “were either unreachable, not accepting new patients, or not in-network.” This information gap can profoundly affect beneficiaries, providers, and the health system, leading to higher bills, additional burdens, and worse care.

Prior Authorization, Coverage Denials, and Appeals

Even when enrollees use in-network providers, they may still face barriers to care. MA plans can impose utilization management requirements like prior authorization to control costs. Doing so may save plans money, but it also delays care, often inappropriately and irreversibly.

Prior authorization is a plan-imposed restriction that requires a beneficiary, usually through their provider, to obtain advance approval for a service to be covered. Intended to promote the delivery of high-value care, evidence suggests it can be misused and otherwise interfere with medically necessary treatments, potentially worsening enrollee health.^{xxv}

Millions of MA enrollees are subject to prior authorization each year, and it is becoming more prevalent.^{xxvi} In 2018, 80% of MA enrollees were in plans that used prior authorization, including for mental health services, ambulances, and inpatient hospital stays.^{xxvii} By 2022, 99% were.^{xxviii} In 2021, MA plans representing 23 million people made over 35 million prior authorization determinations, roughly 1.5 per enrollee.^{xxix} That same year, 84% of physicians reported spikes in prior authorizations; 88% said the claims interfered with continuity of care.^{xxx}

Coverage denials that result from prior authorization can further impede timely access to care by forcing beneficiaries to choose between seeking other treatments, paying out-of-pocket, going without, or getting embroiled in the daunting MA appeals system.^{xxxi} Several independent watchdog reports indicate inappropriate prior authorization denials unnecessarily force millions of beneficiaries into this cycle each year.^{xxxii} Incorrect denials put all affected enrollees at risk. They may be “particularly harmful for beneficiaries who cannot afford to pay for services directly and for critically ill beneficiaries who may suffer negative health consequences from delayed or denied care.”^{xxxiii}

Last year, as in previous years, erroneous denials accounted for nearly one-third of all calls to the Medicare Rights helpline. Most (65%) were about what to do next.^{xxxiv} Too often, there is not a simple solution.

Appealing coverage denials is a complex and time-consuming process. Medicare Rights frequently hears from beneficiaries who don't know how to begin and from those who can't; they don't have time to wait for treatment or wade through what might be a thicket of denials across their care.

Though few enrollees appeal, most who do are successful. In 2021, only 11% of denials were appealed, but more than 80% were overturned.^{xxxv} A 2018 investigation similarly found that while only 1% of prior authorization denials were appealed, 75% were overturned at the first level of review.^{xxxvi} These remarkably high overturn rates signal serious deficiencies with initial plan decisions. Importantly, a successful appeal is not a magic wand—even reversals come at a cost, including care delays and adverse health outcomes.^{xxxvii}

Discussion

People with MA can have trouble accessing their providers and obtaining care due to MA-specific features that OM enrollees generally do not encounter. These risks are not widely understood and do not feature prominently enough in official Medicare communications or industry advertising about MA.

One of the most significant trade-offs between MA and OM is the former's limited and shifting network of providers. But obtaining accurate information about a plan's network and putting it to use, such as by comparing one's coverage options or identifying a provider, is overly difficult. This undermines informed, empowered decision-making and access to care.

Prior authorization and coverage denials are also burdensome, creating delays, stress, and extra work. Low appeal numbers suggest many beneficiaries abandon the process altogether, while disproportionately high overturn rates imply initial coverage decisions are often improper. When plans systematically and inappropriately deny claims, it can erode the individual enrollee's health and chill provider willingness to offer a service going forward, making it harder for even more people to get the care they need.

ⁱ Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

ⁱⁱ 86 FR 16440, 16491.

ⁱⁱⁱ Paige Minemyer, "2022 forecast: Medicare Advantage is the industry's hottest market. Don't expect that to change next year" (December 22, 2021), <https://www.fiercehealthcare.com/payer/medicare-advantage-industry-s-hottest-market-2022-don-t-expect-to-change>.

^{iv} Meredith Freed, *et al.*, "Medicare Advantage 2023 Spotlight: First Look" (November 10, 2022),

<https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.

v *Id.*

vi Allison Rizer, “Is Too Much Choice a Bad Thing?” (July 26, 2021), <https://www.arnoldventures.org/stories/is-too-much-choice-a-bad-thing>.

vii *See, e.g.*, KFF, “Chartpack: Seniors and the Medicare Prescription Drug Benefit” (November 2006), <https://www.kff.org/medicare/poll-finding/chartpack-seniors-and-the-medicare-prescription-drug/>; KFF, “Seniors’ Knowledge and Experience With Medicare’s Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors: Seniors’ Knowledge and Experience with Medicare’s Open Enrollment Period and Choosing a Plan” (October 2012), <https://www.kff.org/medicare/issue-brief/seniors-knowledge-and-experience-with-medicare-open/>.

viii Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

ix *See, e.g.*, Meredith Freed, *et al.*, “More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually” (October 29, 2020), <https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/>; Nancy Ochieng, *et al.*, “A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period” (November 01, 2022), <https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/>.

x Jeannie Fuglesten Biniak, *et al.*, “Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment” (November 01, 2022), <https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/>.

xi Nancy Ochieng, *et al.*, “A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period” (November 01, 2022), <https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/>.

xii Sage Growth Partners, “Hidden Crisis: The Medicare Enrollment Maze” (July 2022), https://sage-growth.ftlbcn.net/wp-content/uploads/2022/07/0242_SGP_MediCare_MarketReport_FINAL.pdf.

xiii U.S. Senate Committee on Finance, “Deceptive Marketing Practices Flourish in Medicare Advantage” (November 3, 2022), <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

xiv 87 Fed. Reg. 1842.

xv Steven Findlay, *et al.*, “The Role of Marketing in Medicare Beneficiaries’ Coverage Choices” (January 5, 2023), <https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices>.

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xvii Faith Leonard, *et al.*, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

xviii Martha Hostetter, *et al.*, “Taking Stock of Medicare Advantage: Choice” (March 3, 2022), <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice>.

xix Medicare Interactive, “Medicare Advantage Plan network comparison chart” (last visited May 23, 2023), <https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/medicare-advantage-plan-overview/medicare-advantage-plan-network-comparison-chart>.

xx Beneficiaries with poor health and high needs are more likely to leave MA or switch plans, citing lack of “coverage of preferred doctors and hospitals” as a leading reason why. Government Accountability Office, “Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight: GAO-17-393” (April 28, 2017), <https://www.gao.gov/assets/gao-17-393.pdf>.

xxi *See, e.g.*, Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report” (March 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf; Centers for Medicare & Medicaid Services, “Online Provider Directory Review Report (January 2018), https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.

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- ^{xxv} U.S. Department of Health and Human Services Office of Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.
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- ^{xxxii} *Id.*
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- ^{xxxiv} Medicare Rights Center, “Medicare Trends and Recommendations: An Analysis of 2020-2021 Call Data from the Medicare Rights Center’s National Helpline” (May 2022), <https://www.medicarerights.org/pdf/2020-2021-helpline-trends-report.pdf>.
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