A Second Cautionary Tale (or Additional Adventures with a Medicare Advantage HMO Plan)

By TOM SWANSON, Chair, TVARA Healthcare Committee

For those of you new to my adventure in attempting to help my mother-in-law navigate the world of Medicare Advantage Health Insurance Plans, I invite you to read my initial "Tale," posted on the TVARA website at mytvara.org.

At the bottom of the first page, select the June 2021 newsletter and scroll down to page 5. For those of you who remember the Tale but not the details, let me refresh your memory.

My 93 -year-old mother-in-law, who has lived in Tampa for more than 70 years, finally really needed to use her health insurance. She aged into Medicare in 1993 and switched from Original Medicare to a Medicare Advantage plan when that plan was created in 1997.

She was a very healthy senior at the time, and the zero-cost premium (along with a later credit posted to the Part B premium paid by a deduction from the Social Security pension, resulting in an increase to her monthly SS payment) was too hard to resist. All she needed to do was find a doctor — and later other medical-service providers participating in the insurance companies' provider network — and all Medicare-approved health claims were covered.

Since she lives in Tampa with lots of healthcare-providers, this was not a problem. So after many years of saving the money not spent on a Medicare Supplement, the time had come to put the Advantage Plan insurance to work.

If you recall, first it was the knees that had been worn out by all her square-dancing activities. Having found the orthopedic doctor she wanted to see at a clinic close to her, she discovered she first needed to schedule an appointment with her Primary Care Physician (PCP) for the purpose of obtaining a referral to the clinic and doctor.

So there was the delay in getting the PCP appointment, then the delay in getting the referral approved by the Advantage Plan (something about the X-rays not being clear or conclusive), added to the normal delay in obtaining a non-emergency orthopedic appointment. But then came the real kick in the knee.

At her initial ortho appointment she was fitted with some high-quality plastic knee braces that had her walking around the room smiling — only to be told after waiting a considerable time that the braces were not approved by her insurance, and she would have to go to an in-network supplier of medical devices to obtain her braces resulting in the need for another appointment.

However, the in-network supplier only had samples used to determine what to order, and the insurance-approved fabric braces would be arriving from China in a month, once ordered, resulting in yet another appointment for final fitting and instructions.

Then there was the hearing aid. I won't go through that adventure again, but, in the end, this was another medical device of a type not covered by her insurance. So in this case, she was no better off than having Original Medicare.

But the real challenge was the fall and broken hip that resulted in her staying in the hospital longer than usual due to the lack of beds available in a Skilled Nursing Facility (SNF) that was "in-network."

She was transferred as soon as a bed became available in a place that accepted her insurance, and needless to say, this was not a five-star facility. Mother-in-law absolutely hated the place and staff. Most worrisome was her claim that the rehabilitation staff was not worth the time spent with them, which time she said was very little.

Now in some of these facilities the rehab staff is a separate organization renting space from the SNF in order to provide services to the patients of the SNF, a situation that results in a lot of successful finger-pointing.

Regardless of progress made or lack thereof, the SNF received a discharge order from her Advantage Plan insurance provider, and she was out the door after several weeks. As you know from my first Tale, she moved in with a daughter on the other side of the state, which took her out of the area covered by her insurance network.

That move resulted in placing her in a Special Enrollment Period, which allowed her to revert to Original Medicare and most important, allowed the purchase of a Plan F Medicare Supplement avoiding any medical underwriting issues. With Original Medicare and the supplement, she was able to quickly choose a new PCP and a rehabilitation tech who would come to the house without worrying about network coverage or referral delays.

And so we ended the first Tale with mother-in-law making great progress in regaining her mobility at her daughter's house, but now having to pay for a Medicare Supplemental Plan and a Drug Prescription Plan (Part D).

Now for the second Cautionary Tale.

Months later, she returned to her home in Tampa and — chaffing at the cost of a Medicare Supplemental Plan when first purchased at age 93 and the loss of the SS health-insurance credit — she switched back to the Advantage Plan during the Fall Open Enrollment Period. That meant she could avoid the premiums for the supplement and drug plan and regain the credit to her SS monthly pension.

Two months later, at the beginning of December, she fell again, this time breaking her pelvis.

Back to the same hospital she went, with the same orthopedic surgeon on duty who treated her first fall. Turned out this doctor belongs to an orthopedic group that does not accept Advantage Plans of any insurance provider. But as you know, when it's an emergency, the cost of most health services provided is covered by any health-insurance plan.

There is little you can do for a broken pelvis, compared to a broken hip or leg. She had experience with the placement of a rod and screws that allowed her to get up and around fairly quickly the first time. With a broken pelvis, you just have to wait for it to begin to heal and start rehab exercises as the pain will allow.

So, once again she was presented with a list of rehab facilities that would accept her Advantage Plan insurance, and once again it was a very short list with only three places rated as high as three stars. And one of those was the previous place she couldn't wait to escape.

So as we drove up to one of the two remaining candidates, it was clear to us that if this was the place, either my wife or I would have to stay with the car at all times. Every window and door on all the surrounding buildings and houses in the neighborhood was framed with burglar bars — not a good start.

We arrived unannounced, and it appeared to take the receptionist by surprise that someone would ask to look around before placing a patient there. It was chaos. Seemed like there were patients roaming everywhere or congregated around exit doors so they could step outside for a quick smoke. Or in wheelchairs maneuvering about or parked facing a wall.

We couldn't leave fast enough.

Now there was only one option left, and thank goodness it looked much better from the start. Vehicles were parked everywhere, signaling another packed house, but the neighborhood looked normal, no burglar bars. Yay!

We approached the door and had to be buzzed in. Wow, controlled access. The entry and waiting area were remarkably calm, with no patients in sight. Once again we had not scheduled a visit, but an administrator soon appeared and was happy to give us a quick tour of one of the nursing wings and of the rehab center. Much better. We left relieved to have found what appeared to be a good place for her to rehab.

The transfer from the hospital was unremarkable, and mother-in-law settled into a room large enough for one hospital bed but containing two. She was confined to her bed and required assistance in doing everything, while her roommate was a long-term-care patient able to get around in a wheelchair. Two very different patients crammed in a small room.

This, as it turned out, was not a good situation, as patients requiring extensive care seemed to be scattered among those needing much less, leading to uneven or at least inconsistent assistance and to difficultly attracting attention.

At first, assistance was focused primarily on pain management, and not much rehabilitation activity was taking place. By the end of the month, the business manager approached mother-in-law with the following news from the front office. Their experience with her Advantage Plan provider was such that they expected a discharge order within the next two weeks for failure to progress. And they suggested that if she were to sign up for a Part D Prescription Drug plan, her Advantage Plan would automatically terminate, and she would revert to Original Medicare effective the beginning of January.

At that point, since she would only have Medicare coverage but no supplemental plan, the Medicare co-pay of $194.50 a day would be her responsibility. If she waited until after a discharge order was issued by her Advantage Plan insurer to revert to Original Medicare, the Medicare coverage would not take effect until the beginning of the next month, leaving her in a private-pay status at $350 a day for the SNF and $175 a day for the rehab charges.

Yes, a charge of more than $1,600 a week.

Since she was still confined to a bed requiring around-the-clock assistance (at least two big people to lift her, for example), she made the switch before the end of the year and took on the co-payment liability, so she could continue skilled-nursing care with at least some semblance of rehab exercise every day.

This was a tough financial hit, but the worst was yet to come. Over the next week, phone conversations were becoming increasingly difficult due to a persistent cough she had developed. Now my wife and I were in Tennessee, and she was in Tampa, so this was becoming so big a problem that we were calling the nursing staff asking about her general health and not her pelvis.

After several days of our inquiring every day we were informed that she tested positive for COVID and was being moved to a COVID wing. That was the first time we had heard that this facility had so many positive cases that a wing was designated for isolating patients. But the problem wasn't the patients, it was the staff. At one point nearly half had tested positive.

As time progressed, mother-in-law was sounding worse, as in getting really sick, and we pressed them every day as to her treatment, which they finally allowed was nothing more

than cough syrup and throat lozenges.

In an attempt for force action, we scheduled a visit to her orthopedic doctor and gave the SNF nursing staff the date, hoping it would spur greater medical assistance in getting her ready for the visit.

It had been two weeks since the positive COVID test. On the morning of the doctor's appointment, we received a call from an SNF employee working from home due to the COVID problem at the facility, saying mother-in-law had been transferred to the emergency room of the closest hospital. The employee was not a nurse and had no details.

After several calls to the ER ending in the same "stable and under evaluation" responses, we were finally told, at the end of the day, that mother-in-law was waiting for a room and would be admitted to the hospital with COVID-induced pneumonia and dehydration, no visitors allowed.

So she had gone into the best SNF in her Advantage Plan insurance network to rehab a broken pelvis and had come out with pneumonia so severe it required emergency treatment. That, thanks to the SNF's lack of control over staff and poor COVID protocol.

AND, now she had gone through an ER and was in a hospital with Original Medicare coverage only, no supplement to cover the other 20 percent of medical charges.

She was in the first hospital for a broken pelvis for two days and transferred to the SNF on the third day. With COVID pneumonia, she was in the hospital for a week, running up a bill for her 20 percent of allowable charges.

At the end of that hospital stay, she once again was presented with the SNF list, but this time the list was extensive and included several five-star facilities. We picked one that also had good reviews posted online, and the difference was stunning. The COVID protocols were similar to those in a hospital. Visitors were limited to two at a time and issued masks and face shields. Staff and patients were tested frequently and staff members quarantined at home if they tested positive. The hallways were wide, the rooms actually large enough for two hospital beds with accessories, a central nursing station had wings radiating out — very well designed. And COVID was not a problem.

Time passed, and mother-in-law regained strength and mobility without the pressure of a discharge order from an Advantage Plan insurance provider. That was good, since recovering from a broken pelvis apparently takes much longer than from a broken hip or leg.

The downside to not having an insurance company pushing the facility to discharge a patient is that it is now up to the patient to put pressure on the facility to end treatment. By the time mother-in-law left the facility, she had used 99 of the 100 days allowed by Medicare for SNF coverage. But she had successfully returned to independent living at her house, without having to move in with a relative to recover, as was the case under the Advantage Plan when she broke her hip.

And now a look at the cost of all of this.

Most all medical cost of the first fall and resulting broken leg were covered by the Advantage Plan. But the insurance provider issued a discharge order after several weeks at an SNF that mother-in-law despised, and came before she reached the ability to return home, forcing her to move in with a relative for months.

That was a less-than-desirable situation for everyone involved. Nothing more to be said about this, or I will be in real trouble.

As a result of the second fall and broken pelvis, she was under a no-weight restriction and flat on her back with no ability to get to and from a bathroom. All of which made the risk of receiving a discharge order from an insurance company intolerable.

As a result of switching to Original Medicare to avoid a discharge order from the Advantage Plan insurance provider, she was able to get the care she needed to return home. But because she could not obtain supplemental coverage (no circumstances allowing for a Special Enrollment Period), her liability for the medical bills approached $20,000.

Had she kept the Original Medicare plan and her $350-a-month Plan F Supplemental Plan, along with an $85-a-month Plan D Prescription Drug Plan, and given up the $200-a-month Part B premium credit, she would have avoided the $20,000 and would have avoided the less-than-desirable SNF and perhaps avoided COVID pneumonia in spite of being vaccinated and boosted.

It's never good to be sent to an SNF to rehab a broken pelvis, only to wind up in an ER with pneumonia and dehydration. Quality of care and the ability to select your health-provider is worth the cost. With an Advantage Plan, you get what you pay for — sooner or later!