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When Hospitals Ditch Medicare Advantage Plans, Thousands of Members Get To Leave, Too

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But KFF Health News reports some older Americans get lost in the transitions. At least 41 hospital systems have dropped out of 62 Medicare Advantage plans serving all or parts of 25 states since July. Here's what to do so you don't lose Medicare coverage.

By Susan Jaffe

For several years, Fred Neary had been seeing five doctors at the Baylor Scott & White Health system, whose 52 hospitals serve central and northern Texas, including Neary's home in Dallas. But in October, his Humana Medicare Advantage plan — an alternative to government-run Medicare — warned that Baylor and the insurer were fighting over a new contract. If they couldn't reach an agreement, he'd have to find new doctors or new health insurance.

"All my medical information is with Baylor Scott & White," said Neary, 87, who retired from a career in financial services. His doctors are a five-minute drive from his house. "After so many years, starting over with that many new doctor relationships didn't feel like an option."

After several anxious weeks, Neary learned Humana and Baylor were parting ways as of this year, and he was forced to choose between the two. Because the breakup happened during the annual fall enrollment period for Medicare Advantage, he was able to pick a new Advantage plan with coverage starting Jan. 1, a day after his Humana plan ended.

Other Advantage members who lose providers are not as lucky. Although disputes between health systems and insurers happen all the time, members are usually locked into their plans for the year and restricted to a network of providers, even if that network shrinks.

Unless members qualify for what's called a special enrollment period, switching plans or returning to traditional Medicare is allowed only at year's end, with new coverage starting in January.

But in the past 15 months, the Centers for Medicare & Medicaid Services, which oversees the Medicare Advantage program, has quietly offered roughly three-month special enrollment periods allowing thousands of Advantage members in at least 13 states to change plans. They were also allowed to leave Advantage plans entirely and choose traditional Medicare coverage without penalty, regardless of when they lost their providers. But even when CMS lets Advantage members leave a plan that lost a key provider, insurers can still enroll new members without telling them the network has shrunk.

At least 41 hospital systems have dropped out of 62 Advantage plans serving all or parts of 25 states since July, according to Becker's Hospital Review. Over the past two years, separations between Advantage plans and health systems have tripled, said FTI Consulting, which tracks reports of the disputes.

CMS spokesperson Catherine Howden said it is "a routine occurrence" for the agency to determine that provider network changes trigger a special enrollment period for their members. "It has happened many times in the past, though we have seen an uptick in recent years."

Still, CMS would not identify plans whose members were allowed to disenroll after losing health providers. The agency also would not say whether the plans violated federal provider network rules intended to ensure that Medicare Advantage members have sufficient providers within certain distances and travel times.

The secrecy around when and how Advantage members can escape plans after their doctors and hospitals drop out worries Sen. Ron Wyden of Oregon, the senior Democrat on the Senate Finance Committee, which oversees CMS.

"Seniors enrolled in Medicare Advantage plans deserve to know they can change their plan when their local doctor or hospital exits the plan due to profit-driven business practices," Wyden said.

The increase in insurer-provider breakups isn't surprising, given the growing popularity of Medicare Advantage. The plans attracted about 54% of the 61.2 million people who had both Medicare Parts A and B and were eligible to sign up for Medicare Advantage in 2024, according to KFF, a health information nonprofit that includes KFF Health News.

The plans can offer supplemental benefits unavailable from traditional Medicare because

the federal government pays insurers about 20% more per member than traditional Medicare per-member costs, according to the Medicare Payment Advisory Commission, which advises Congress. The extra spending, which some lawmakers call wasteful, will total about $84 billion in 2025, MedPAC estimates. While traditional Medicare does not offer the additional benefits Advantage plans advertise, it does not limit beneficiaries' choice of providers. They can go to any doctor or hospital that accepts Medicare, as nearly all do.

Sanford Health, the largest rural health system in the U.S., serving parts of seven states from South Dakota to Michigan, decided to leave a Humana Medicare Advantage plan last year that covered 15,000 of its patients. "It's not so much about the finances or administrative burden, although those are real concerns," said Nick Olson, Sanford Health's chief financial officer. "The most important thing for us is the fact that coverage denials and prior authorization delays impact the care a patient receives, and that's unacceptable."

The National Association of Insurance Commissioners, representing insurance regulators from every state, Puerto Rico, and the District of Columbia, has appealed to CMS to help Advantage members.

"State regulators in several states are seeing hospitals and crucial provider groups making decisions to no longer contract with any MA plans, which can leave enrollees without ready access to care," the group wrote in September. "Lack of CMS guidance could result in unnecessary financial or medical injury to America's seniors."

The commissioners appealed again last month to Health and Human Services Secretary Robert F. Kennedy Jr. "Significant network changes trigger important rights for beneficiaries, and they should receive clear notice of their rights and have access to counseling to help them make appropriate choices," they wrote.

The insurance commissioners asked CMS to consider offering a special enrollment period for all Advantage members who lose the same major provider, instead of placing the burden on individuals to find help on their own. No matter what time of year, members would be able to change plans or enroll in government-run Medicare.

Advantage members granted this special enrollment period who choose traditional Medicare get a bonus: If they want to purchase a Medigap policy — supplemental insurance that helps cover Medicare's considerable out-of-pocket costs — insurers can't turn them away or charge them more because of preexisting health conditions.

Those potential extra costs have long been a deterrent for people who want to leave

Medicare Advantage for traditional Medicare.

“People are being trapped in Medicare Advantage because they can’t get a Medigap plan,” said Bonnie Burns, a training and policy specialist at California Health Advocates, a nonprofit watchdog that helps seniors navigate Medicare.

Guaranteed access to Medigap coverage is especially important when providers drop out of all Advantage plans. Only four states — Connecticut, Massachusetts, Maine, and New York — offer that guarantee to anyone who wants to reenroll in Medicare.

But some hospital systems, including Great Plains Health in North Platte, Nebraska, are so frustrated by Advantage plans that they won’t participate in any of them.

It had the same problems with delays and denials of coverage as other providers, but one incident stands out for CEO Ivan Mitchell: A patient too sick to go home had to stay in the hospital an extra six weeks because her plan wouldn’t cover care in a rehabilitation facility.

With traditional Medicare the only option this year for Great Plains Health patients, Nebraska insurance commissioner Eric Dunning asked for a special enrollment period with guaranteed Medigap access for some 1,200 beneficiaries. After six months, CMS agreed.

Once Delaware’s insurance commissioner contacted CMS about the Bayhealth medical system dropping out of a Cigna Advantage plan, members received a special enrollment period starting in January.

Maine’s congressional delegation pushed for an enrollment period for nearly 4,000 patients of Northern Light Health after the 10-hospital system dropped out of a Humana Advantage plan last year.

“Our constituents have told us that they are anticipating serious challenges, ranging from worries about substantial changes to cost-sharing rates to concerns about maintaining care with current providers,” the delegation told CMS.

CMS granted the request to ensure “that MA enrollees have access to medically necessary care,” then-CMS Administrator Chiquita Brooks-LaSure wrote to Sen. Angus King (I-Maine).

Minnesota insurance officials appealed to CMS on behalf of some 75,000 members of Aetna, Humana, and UnitedHealthcare Advantage plans after six health systems announced last year they would leave the plans in 2025. So many provider changes caused “tremendous problems,” said Kelli Jo Greiner, director of the Minnesota State Health Insurance Assistance Program, known as a SHIP, at the Minnesota Board on Aging. SHIP counselors across the country provide Medicare beneficiaries free help choosing and using Medicare drug and Advantage plans.

Providers serving about 15,000 of Minnesota’s Advantage members ultimately agreed to stay in the insurers’ networks. CMS decided 14,000 Humana members qualified for a network-change special enrollment period.

The remaining 46,000 people — Aetna and UnitedHealthcare Advantage members — who lost access to four health systems were not eligible for the special enrollment period. CMS decided their plans still had enough other providers to care for them.

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