



CMA Weekly Alert – November 30, 2006

## **BRING FAIRNESS AND FISCAL SOUNDNESS BACK TO MEDICARE**

### **Background**

The traditional Medicare program works. Medicare was created because private insurers were unwilling to provide health coverage to elders. Before Medicare, only about 50% of people 65 or older had health insurance. By 1970, four years after Medicare went into effect, 97% of those 65 and older had health insurance. Access to health insurance coverage meant that more older people received needed medical care; this in turn caused life expectancies for older people to increase at a higher rate than life expectancies for the general population. Access to health insurance also meant that Medicare beneficiaries and their families no longer had to bear the full cost of their care, helping to reduce poverty among older people and their families.<sup>1</sup>

Rarely reported but true: Medicare beneficiaries *like* Medicare. In a study comparing Medicare beneficiaries with individuals covered by private, primarily employer-sponsored health insurance, researchers found a greater satisfaction rate among Medicare beneficiaries than among people with private insurance. Despite their poorer health and lower incomes, Medicare beneficiaries felt more secure in their health coverage than those in the general population with private insurance. They were more positive that they could access necessary health care in the future.<sup>2</sup>

Since 1997, however, changes to Medicare enacted under the guise of modernization and/or fiscal responsibility have undermined this previously effective, fiscally sound program that has long been appreciated and respected by those who use it. Steps need to be taken to bring fairness and fiscal soundness back to Medicare so that older people and people with disabilities will continue to have the comprehensive and affordable health care coverage that Medicare has provided in the past.

This *Weekly Alert* proposes changes to traditional Medicare and Medicare Advantage that will protect the integrity of the Medicare program. A future *Alert* will address proposed changes to Medicare Part D.

### **Recommendations**

#### **1. Reverse the Trend Toward Privatization of Medicare**

The past 10 years have seen a shift in Congressional and executive branch policy away from Medicare as a social insurance program and toward the privatization of Medicare. Medicare Part C, now called the Medicare Advantage program, has been expanded to include a vast array of private options. Medicare Part D drug coverage is offered *only* through private plans. The Centers for Medicare & Medicaid Services (CMS) actively promotes enrollment in private managed care plans over the traditional program on its web site and in its outreach and education materials. While Medicare continues to be pushed away from a comprehensive social insurance program and toward an alphabet soup of private options, reliance on private health plans has not been an effective or fiscally sound strategy for Medicare.

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<sup>1</sup> Marilyn Moon, *Medicare: A Policy Primer* (Urban Institute Press 2006).

<sup>2</sup> Karen Davis, Cathy Schoen, Michelle Doty, Katie Tenney, *Medicare Versus Private Insurance: Rhetoric and Reality* (Health Affairs Web Exclusive October 2002), <http://www.healthaffairs.com>.

- **Private Health Plans Undermine the Security and Reliability Provided by Medicare**

Private managed care plans move in and out of the Medicare program depending on their profitability, disrupting enrollee relationships with their health care providers and their access to health care in general. Unlike traditional Medicare, private plans offer different extra benefits and include different cost sharing responsibilities. By using an “actuarially equivalent” benefit package, the private Medicare Advantage plans can increase cost-sharing for Medicare covered services utilized by sicker beneficiaries, thereby discouraging enrollment by people who need a lot of health care. The inequity in benefits may result in uneven care, threatening the reliability of the health insurance program.<sup>3</sup>

- **Private Health Plans Do Not Save Money**

Analysts continue to report that, on average, Medicare Advantage plans are paid more for their enrollees than Medicare would have paid had the enrollees remained in the original Medicare program.<sup>4</sup> The comparisons in payment rates are based on traditional Medicare’s payments on behalf of an average beneficiary. Because private plans attract beneficiaries who are healthier than the general Medicare population, they are probably overpaid even more than analysts project. Further, the Medicare Modernization Act of 2003 also sets aside an additional \$10 billion to be paid through 2013 to ensure access to regional Preferred Provider Plans (PPOs). These extra payments are *on top of* the higher payments already available to all MA plans.

- **Beneficiaries Prefer the Traditional Medicare Program**

A survey that found a high satisfaction rate with Medicare among beneficiaries aged 65 and older also found that older people prefer the traditional Medicare program over private health plans.<sup>5</sup> While the number of beneficiaries enrolled in private plans has increased, the overwhelming majority of beneficiaries (83%) remain in the traditional program.<sup>6</sup>

## Proposed Solutions

Promote fairness by:

- Precluding Medicare Advantage plans from offering actuarially equivalent benefit packages that discourage sicker beneficiaries from enrolling in their plans
- Providing effective oversight of CMS to ensure that the agency does not unfairly promote managed care options over the traditional Medicare program.

Protect the fiscal integrity of Medicare by:

- Revising the Medicare Advantage payment mechanism so that Medicare Advantage plans are not paid more than traditional Medicare, thereby
- Eliminating the \$10 billion fund to entice regional PPOs to participate in Medicare Part C.

## 2. Equal Treatment for Beneficiaries with Disabilities:

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<sup>3</sup> King, Kathleen M. and Mark Schlesinger, eds., *Final Report of the Study Panel on Medicare and Markets-The Role of Private Insurance in Medicare: Lessons from the Past, Looking to the Future* (National Academy of Social Insurance, September 2003).

<sup>4</sup> Brian Biles, MD, *Payments to Medicare Advantage Plans Exceed Fee-For-Service Costs: Options for Medicare Savings from 2007 – 2011*, (George Washington University, Sept. 15, 2006). B. Biles, L. Hersch Nicholas, B. S. Cooper, E. Adrion, and S. Guterman, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised*, The Commonwealth Fund, November 2006.

<sup>5</sup> Kaiser Family Foundation, Harvard School of Public Health, *National Survey of the Public’s View on Medicare* (June 2003) <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14305>

<sup>6</sup> Kaiser Family Foundation, “Tracking Medicare Prescription Drug and Health Plans: Monthly Report for October 2006,” <http://www.kff.org/medicare/upload/medicaretracking1006.pdf>.

Of the 43 million people who are eligible for Medicare, 15 %, or nearly 6.45 million are eligible because they receive Social Security Disability (SSDI) benefits.<sup>7</sup> Once they meet the eligibility criteria, they are generally entitled to the same benefits as people who receive Medicare based on age.<sup>8</sup> Nevertheless, eligibility criteria and certain coverage limitations disadvantage many people with disabilities.

- **The 24-Month Waiting Period Increases the Number of Individuals Who are Uninsured**

When Medicare was expanded in 1972 to include people with significant disabilities, Congress included a requirement that they wait 24 months after they receive their first SSDI check before they qualify for Medicare.<sup>9</sup> The only reason for the waiting period was to reduce the cost of the expansion. Because of the 24-month Medicare waiting period, an estimated 400,000 Americans with disabilities are uninsured and many more are underinsured at a time in their lives when the need for health coverage is most dire. According to the Commonwealth Fund, 4% of these people die during the waiting period.<sup>10</sup>

- **Cost-Sharing Restrictions Discriminate Against People with Mental Illness**

Medicare beneficiaries are generally required to pay a 20% co-insurance for doctor and other medical services covered under Medicare Part B; Medicare pays the other 80%. The Medicare statute creates an exception for services provided by a doctor or comprehensive outpatient rehabilitation facility in connection with treatment of a mental, psychoneurotic, or personality disorder. Beneficiaries are required to pay half the cost (a 50% co-insurance) for services that fall within the exception. In 2001, more than a quarter (28%) of those who received SSDI did so on the basis of a mental disorder.<sup>11</sup> Thus, many people who receive Medicare on the basis of disability are paying more for the health care they need to treat their chronic condition than other Medicare beneficiaries.

- **Medigap Protections are Often Not Available to Younger Medicare Beneficiaries with Disabilities**

Medicare Supplement Insurance, also known as “Medigap” insurance, provides supplemental health insurance coverage for Medicare beneficiaries in the traditional Medicare program. Beneficiaries may purchase one of the standard Medigap plans to fill in the “gaps” in Medicare coverage, including co-payments and deductibles. All individuals who are newly entitled to Medicare *based on age* have a right to guaranteed issue of any Medigap policy which is offered for sale for the first six months after their Medicare entitlement begins. Insurance companies are not required by federal law to offer the same range of Medigap policies to Medicare beneficiaries with disabilities that they offer for sale to Medicare beneficiaries over age 65. Some, but not all, states require insurance companies to sell designated Medigap policies to Medicare beneficiaries with disabilities.

## Proposed Solutions

Promote fairness by:

- Eliminating the 24-month waiting period for Medicare coverage based on disability.
- Eliminating the disparate treatment for mental health services so that the co-insurance is the same as for other Part B services.
- Extending the guaranteed issue protections to younger people with disabilities.

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<sup>7</sup> Kaiser Family Foundation, Fact Sheet: Medicare At A Glance (July 2006), <http://www.kff.org/medicare/upload/1066-09.pdf>.

<sup>8</sup> People with end stage renal disease (ESRD) cannot enroll in Medicare Advantage plans.

<sup>9</sup> The 24-month waiting period does not apply to people with ESRD or to people with ALS (Lou Gehrig’s disease).

<sup>10</sup> Dale and Verdier, *Elimination of Medicare’s Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs* (The Commonwealth Fund, July 2003).

<sup>11</sup> Jans, L., Stoddard, S. & Kraus, L. (2004). *Chartbook on Mental Health and Disability in the United States*. An InfoUse Report.

Washington, D.C.: U.S. Department of Education, National Institute on Disability and Rehabilitation Research. [http://www.infouse.com/disabilitydata/mentalhealth/4\\_5.php](http://www.infouse.com/disabilitydata/mentalhealth/4_5.php).

### 3. Bring Equity Back to the Medicare Appeals Process

Medicare coverage is often denied when it should be granted. Whatever the underlying reasons for the denial, Medicare includes an appeals system that is designed, at least in theory, to reverse erroneous denials and to correct mistakes. Until recently, advocates have had great success in winning claims at the administrative law judge (ALJ) level of review, the first level of appeal at which the beneficiary had an opportunity to meet face to face with an impartial adjudicator. Recent changes to the Medicare appeals process, and in particular to the ALJ level of review, have brought into question the fairness of the system.

- **New Regulations Deprive Beneficiaries of the Opportunity for a Face-to-Face ALJ Hearing**

One of the most dramatic changes made by new regulations that were phased in starting in 2005 was to virtually eliminate the beneficiary's right to a face-to-face in-person hearing with an ALJ. The regulations state that an ALJ hearing may be held by video conferencing (VTC), by telephone, or in-person. They give the ALJ discretion to set the time and place of the hearing and create a presumption that the hearing will be held by VTC if the equipment is available. If the beneficiary requests an in-person hearing, the ALJ has discretion, after consulting with the managing attorney in the regional field office, to grant the request if good cause is shown. Although Medicare beneficiaries are supposed to be accorded the same hearing and appeal rights as Social Security claimants, the Social Security regulations provide greater protection for individuals: A claimant's request for an in-person hearing will automatically be granted if it is timely filed. Additionally, although the Medicare statute requires the geographic distribution of ALJs, the ALJs are housed in only four sites: Miami, Florida; Arlington, Virginia; Cleveland; Ohio; and Irvine, California. Beneficiaries whose request for an in-person hearing has been granted have been told that they must come to one of the four sites, regardless of the distance from their home.<sup>12</sup>

#### Proposed solutions

Promote fairness and equity by

- Giving Medicare beneficiaries the same appeal rights as Social Security claimants, and provide for the automatic granting of a request for an in-person hearing when made on a timely basis.
- Requiring that in-person ALJ hearings be held in at least two or three locations in each state, depending on the geographic size of the state.

#### Conclusion

Medicare has been one of the most successful social programs in our nation's history. It has offered effective, efficient health care for a previously marginalized population. Efforts to privatize Medicare serve only to fragment and raise the costs of this historically reliable enterprise. It is imperative that efforts be made to preserve Medicare as a single, comprehensive, nationally available program.

**Discuss these issues live online with attorney Vicki Gottlich tomorrow, Friday December 1, at 1:00 PM, at [http://www.democracyinaction.org/dia/organizations/fairmedicare/blog/comments.jsp?blog\\_entry\\_KEY=22072&t=&message=Successfully+updated+Blog+comment+information](http://www.democracyinaction.org/dia/organizations/fairmedicare/blog/comments.jsp?blog_entry_KEY=22072&t=&message=Successfully+updated+Blog+comment+information).**

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<sup>12</sup> Social Security policy provides for a hearing to be held within 75 miles of the individual's residence, and gives SSA authority to reimburse travel expenses for the beneficiary, his/her representative or an un subpoenaed witness who travels more than 75 miles to attend the hearing. Social Security Program Operations Manual System (POMS), GN 03101.140 Appeals.